

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

A study on the discernment by occupational therapists on whether mental health service users' occupations of a spiritual nature are health seeking behaviours or manifestations of illness

Ka Yan Hess

Student no.: HXXXKAX001

Thesis Presented for the Degree of
MASTER OF SCIENCE (OCCUPATIONAL THERAPY)
In the Division of Occupational Therapy
Department of Health and Rehabilitation Sciences

FACULTY OF HEALTH SCIENCES, UNIVERSITY OF CAPE TOWN

Supervisor: Dr. Elelwani Ramugondo

May 2011

Declaration

I, Ka Yan Hess, hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise), and that neither the whole work, nor any part has been, is being, or is to be submitted for another degree in this or any other University.

I empower the University of Cape Town to reproduce for the purpose of research either the whole or any part of the contents in any manner whatsoever.

Signed:

Signed by candidate

Date: 16th May, 2011

Appreciations

This research project would not have been possible without the support and assistance of many individuals and organisations. Hence, I would like to extend my appreciation to the following people and organisations:

The participants, who willingly shared their experiences and knowledge so that we may all learn.

My supervisor, Dr. Elelwani Ramugondo for your wisdom, support and encouragement. You have been the guiding light beside me throughout this journey. Thank you for being so positive and detailed, as well as the understanding from your family that I am sometimes the reason why you are working late at night.

The Occupational Therapy Departments at the Associated Psychiatric Hospitals for welcoming me into their space for this research project. In particular, everyone in my OT department at Valkenberg Hospital. Thank you for all your support and encouragement along the way.

The University of Cape Town.

To Maddie for your crystal clear thinking and Gudrun for your patience and assistance in editing, both helped the study from start to finish.

And my family both the Ho's and the Hess's, especially Aaron for your constant support and Bridgid for your practical assistance, my parents and grandparents who planted an early seed to thirst for knowledge and understanding in me.

Preface

Accounts on both the experience of spirituality and assumptions were continuously revisited and reflected on.

A. *Small beginnings*

Researcher's experience of spirituality

As a person

I was born in Hong Kong, the fragrant harbour where I spent the first twelve years of my life. Hong Kong is an interesting city, a city where the East meets the West. I now live in South Africa and moved here when I was twelve years old. I have always lived my life in the parallel of different cultures.

One of my earliest memories about spiritual occupations was watching my grandmother burning incense and speaking to the Gods and ancestors; she did this as part of her daily routine. In my immediate family however there was no explicit religious belief. We celebrated every Chinese festival with burning incense, offering delicious food (it always included steamed whole chicken, crispy roasted pork belly, green tea and rice wine) and burning paper-made items such as money that had "united bank of heaven and the underworld" printed on it. This was my culture and was quite normal to me; just as knowing that it is disrespectful to blow out the flame of the incense as we are mortal beings. The flame is always put out with the wave of your hands. The offerings were done to invite the good spirits into our house to eat and drink so they would continue to bless and protect us. Although my family was not religiously inclined, one thing was certain. We believed that there was something or someone watching us from above. For example, as children, my mother would often remind us not to kick stones on the road or walk too closely to walls at night as it is believed that spirits might be resting on these objects. One needs to say 'excuse me' when you want to pass through a dark passage way to ask the spirits to let you come through.

In the Chinese culture, it is perfectly possible for certain individuals that are born under particular condition of the stars to have the gift of 'seeing spirits'. I discovered that I was such a person. This may sound rather absurd to readers from other backgrounds, however, throughout my childhood I saw a particular ghost doing the same thing three times in three different houses that I lived in. The first time I met her, I was an eight old year that had just woken up from an afternoon nap. As I walked out of my room, I saw a woman without a face with long messy wavy hair in a snow white torn dress carrying a blood-red handbag. She floated through the corridor of my house and out the front door. At the time, I thought I must have been dreaming. I saw her two more times doing the same thing in different houses in Hong Kong. The way I made sense of this was to understand her as an ancestor, coming to visit me and was checking that everything was in order at my house. I was not afraid, I merely watched her passing by three times with respect in silence. And yes, I still believe in the spirit world. I have had a few auspicious dreams where a few of my family members visited me on the seventh day after they died. They told me symbolically where they were going to in their next life. Note: the seventh day after death is significant in the Chinese culture, as that is the day where the dead person is allowed to visit the world one last time before they move on. Hence, often, it is expected that they would visit family members on this day. However, I was the only one they visited as no-one else in the family had such a dream on the seventh day after their death.

I attended a Catholic private primary school in Hong Kong, where a nun was the school's headmistress. We had a beautiful statue of Mary standing in a mosaic tiles decorated little hill in a corner of the school's play ground. I became very Christian under the influence of the Bible that was taught at school. Having been taught that there is only one God and that Jesus was the only way to God, I began to reject the Chinese rituals that I had taken part in. As a school child, I thought if Jesus was the only way, then everything else must have been wrong and evil.

I remember myself praying every single night in my primary school years all the way to my second year of high school in South Africa after I moved. God used to have a voice and he talked to me in my prayers. But one day, it all stopped when I was in grade nine.

I still remember this day in 1998, as I believe it was a significant day in my life where I had finally, in Buddhist's term, become enlightened. A very close friend of mine at the time and I

were chatting during a school sport day. I do not remember what we were talking about, but I remember she said 'but Anita you are so good, how can you not be of God?' She went on to say 'if you are not a Christian anymore, I can no longer be your friend.' It hurt and I was riddled with fear of rejection by both her and God. I sat that night in the boarding house wondering what would happen to my kind-hearted grandfather whom passed away in 1997 shortly after I arrived in Cape Town... does it mean that just because he was not Christian, God would be so harsh that he would have to burn in hell eternally." From that day on, I struggled with spirituality. It felt like a fight inside me between God and Buddha and neither was winning my heart. I continue with this struggle today and realise how very indebted I am to them both for making me who I am today. I started praying again and have begun to understand that I can see God around me through the people I encounter every day. I now pray to a silent universal God and wonder how God could be in the sole ownership of any one religion.

So how can you decide whether voices that we hear are from the edge of a psychosis or are life-giving? Might I be pathologised for seeing and hearing things that do not seemingly exist in a biomedical scientific western world?

As an occupational therapist

Spirituality was the topic of a lecture during my final year at the University of Cape Town. I remembered it being a confusing one, where many students in the same class seemed confused or anxious during this lecture. Some became very fixed on their beliefs and it reminded me of my personal struggle since that incident in grade nine. I found myself wondering, what they would think about my 'seeing a ghost' in relation to their spirituality and understanding of the spiritual world. I did not dare share my experience and opinion as I did not want to be labelled according to psychiatry lectures that I was a 'psycho' who had hallucinations since she was eight with a continuous delusion of 'having special powers of seeing spirits'.

These experiences have led me to ponder about spirituality in the context of psychiatry. I live between two religions and two cultures, remaining on the cross-roads of life. I have even married a man of sincere Christian faith, who is also faced by many similar dilemmas of

‘exclusion’. I have had another moment of enlightenment when I was at Fountain House (a prevocational skill training place for people with psychiatric illnesses) for a practical block in my final year as an undergraduate. It was a particularly boring afternoon where most members had gone home after lunch and I sat observing a member who furiously wrote about his religious beliefs on the whiteboard that was there. I sensed the uncomfortable air amongst the staff as his action was being ignored. Upon my enquiries, staff expressed that they did not want to be involved as they suspected that the member might have been ill and was busy entertaining his religious delusions. I went and spoke to him. I do not remember what he said to me, whether it was logical or delusional, but I remembered how happy he seemed when there was someone who listened. This was the moment when I thought how helpful it may be if mental health professionals (occupational therapists included) were not so uncomfortable with spirituality in a psychiatry setting. It was from these life experiences that I selected this topic for research when I began my studies for a master’s degree at the University of Cape Town in 2008.

After my community service year in Mpumalanga, South Africa in 2007, I started working in my current job at Valkenberg hospital as the male admission unit occupational therapist. I did not encounter many dilemmas with spiritual occupations. However, I believe that there were two clients who came to teach me a lesson in spirituality. The first was a coloured male in his thirties who expressed that he would like to stop working as a car mechanic for his father and engage with studying energy healing as part of a new direction that was more spiritually in line with him at that moment in time. This new goal of his was discussed in the ward round as something unrealistic and delusional because this was not what his baseline functional state was according to the information from his family. It frustrated me as I asked within myself ‘why is being back to baseline good enough if it was the state the person became ill from in the first place?’ and ‘what is wrong with someone who wants to change his life direction? Would people have made this judgement if he was not in this hospital? What has happened to seeing humans as developing beings?’ Given that my thinking was confirmed by another colleague who comes from the same cultural background as this man, I was unimpressed with the fact that this man’s autonomy was seen as something that required more medication. The second person was a light hearted Xhosa man in his sixties who decided he was going to become a sangoma after he made a white and red necklace at one of my beading groups. He could be seen wearing it over his forehead all the time for a month after that particular beading group as that was what sangomas-to-be would

wear in training to signify their status. He would come into the ward grounds with it on his head, making it quite a laughing matter for others in the multidisciplinary team as they tried to make sense of this action. From my experience as a student and a clinician, I had come to feel that it appears there is little knowledge amongst mental health professionals about what to do with clients' spiritual expressions, behaviours or occupational engagements. It was something that was either ignored due to fear or laughed at or a reason to increase medication. Although, I did not disagree with the idea that one should not enhance psychiatric symptoms I also thirsted for the client's own voice in telling us why they do what they do in a spiritual context, without judging it to be pathological. This led me to become interested in finding out more how occupational therapists deal with situations like this. I guess, by searching for answers about spirituality in my professional life, it touches on my own personal struggles with it. Through this research study process, the one lesson I have taken from it has been that there are so many ways to connect with the spiritual world so that my hybrid God between the Christian God and Buddha is okay if that is what I believe in. And yes, I can continue to find spirituality in my work as an occupational therapist too as I get the opportunity to be part of my clients' lives when we work together. Just like that our lives cross one another and it is not always only the clients who learn or benefit from the therapeutic relationships.

B. Assumptions

- The spiritual world is all around us and it has many forms.
- People are unique and they will connect with the spiritual world differently depending on their lived experiences, culture and beliefs.
- Spiritual occupations associated with the different ways of connecting to the spiritual world have impact to the person's health, may it be positive or negative.
- Spirituality is the source of life energy, it flows within us and urge us to find meaning and purpose in our lives.
- Spirituality is also a life energy that flows back into the bigger cosmos when our body no longer exist. Ultimately, making us interconnected in a transpersonal dimension.
- People are spiritual no matter what their status of health maybe and often they seek to make meaning of their illnesses in a spiritual way before considering it in a scientific way.

- Occupational therapists are obligated to engage with their clients about spirituality from the basis that it is a motivating life force towards engaging with occupations from which meaning can be experienced, spirituality can be expressed and health can be gained from.

University of Cape Town

ABSTRACT

Spirituality has been a topic of debate in occupational therapy. However, incorporating spirituality into occupational therapy practice has remained a challenge due to its subjective nature. Limited exploration has been done on how clinical reasoning may assist occupational therapists in this regard within mental health practice, especially within the African context. In this study, the clinical reasoning process used by occupational therapists in determining whether their clients' spiritual occupations were health seeking behaviours or manifestations of a psychiatric illness are described. Five occupational therapists within mental health practice were interviewed and transcribed data were analysed using Nvivo and Stake (2006)'s cross case analysis worksheets. Member checking, peer reviews, research journal, data triangulation and visual presentation of data were used to enhance research rigor.

Three themes emerged from the study: a) Clinical Reasoning: Complex, dynamic and multi-layered; b) Multiple resources: People as key; and c) Rewarding and challenging experience. The themes highlight a need for dialogue within occupational therapy to develop contextually relevant client centeredness and a clearer language around clinical reasoning processes employed by occupational therapists. "Underground practice" emerged as a construct with potential to complement strategies for negotiating politics by occupational therapists in the workplace as suggested by Pollard et al (2009). Finally, four critical questions are suggested to aid occupational therapists in discerning whether their clients' spiritual occupations are health seeking behaviours or a manifestation of psychiatric illness.

Keywords: Spirituality, clinical reasoning, spiritual occupation (or occupation of a spiritual nature) and client centeredness.

TERMS AND DEFINITIONS

Client centeredness: Also known as client centred rehabilitation (Christiansen & Baum, 1997: pg 593). It is defined as ‘a therapeutic orientation whereby clients engage the assistance and support of a therapist to facilitate the achievement of their goals, in an environment of understanding, trust and acceptance.’ (Christiansen & Baum, 1997: pg 593).

Discernment is “the faculty of discerning; discrimination; acuteness of judgment and understanding” (Dictionary.com, 2011). For the purpose of the thesis, it is best described by Wikipedia (2011) as “...a term used to describe the activity of determining the value of a certain subject or event” that “...[go] past the mere perception of something, to making detailed judgments ...”

Spiritual occupations (or ‘occupation of a spiritual nature’ as referred to in this study) “...encompasses a variety of activities specifically imbued with spiritual meanings and effects that have been performed by human beings over many generations and across all cultures... [which] can be enacted at both individual and community levels” (Kang, 2003: pg 95-96).

Spiritual occupations can be found in three different ways (Kang, 2003). One, as millennial wisdoms in the form of “... discourses, disciplines and practices, stories, drama, music, festivals, and rituals”. Secondly, as texts and practices of ancient and classical cultural spiritual traditions such as “Yoga-Sutra, Pali Nikayas, Old and New Testaments, Zohar, Sufi and Zen stories”. Thirdly, as diverse collective activities including “... prayer, scripture reading, devotional practices such as singing or chanting, meditation, yoga, tai-chi, participation in communities of faith, expressive arts such as dance, theatre, sculpture and painting, dreamtime stories, rituals of healing, journaling and autobiography, communing with nature, bushwalking, and social or ecological activism”. (Kang, 2003: pg 99)

Occupational therapy: Occupational therapy is “a client-centred health profession concerned with promoting health and well being through occupation” (World federation of occupational therapy (WFOT.org), 2004). Its primary goal is “to enable people to participate in the activities of everyday life... [by] working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement” (WFOT.org, 2004). This definition from the WFOT.org (2004)

forms the basis of many occupational therapy associations' definition of occupational therapy, including South Africa, Australia and Britain. The Canadian association add that occupational therapy is an "art and science of enabling engagement in everyday living, through occupation..." as well as a means to promote justice and inclusivity for equal participation in society(Townsend & Polatajko, 2007: pg 372).

Spirituality: In this study, spirituality is viewed with the consideration of two definitions. Firstly as "experiencing a meaningful connection to our core selves, other beings, the world, and/or a greater power, as expressed through our reflections, narratives, and actions, within the context of space and time" as described by Schulz (2008: pg 264), and secondly as "[an] essence of the self", "[a] source of will and intention" and "[a] source of meaning" as suggested by McColl (2000). These definitions were used as guidelines only in the current study, as participants' subjective view on spirituality were seen as valuable in describing their work with spiritual occupations.

Contents

CHAPTER ONE: INTRODUCTION

1.Introduction to the study.....	1
1.2. Literature Review	2
1.2.1 Defining Spirituality.....	2
1.2.2 Spirituality as positive health seeking behaviour	2
1.2.3 Spirituality as symptomology in psychiatry and the African traditional context.....	4
1.2.4 Occupational therapy and mental health	5
1.2.5 Spirituality and occupational therapy.....	9
1.2.6 Clinical reasoning in occupational therapy	11
1.3. Purpose and rationale of the study	16
1.4. Research Question	16
1.5. Aim	16
1.6. Objectives.....	16

CHAPTER TWO: METHODOLOGY

2.Introduction to methodology	18
2.1 Qualitative research approach.....	18
2.2 Multiple Case study – confirming suitability.....	19
2.3 Research process (Creswell, 2003; Fontana & Frey, 2008).....	20
2.3.1 Gaining permissions and creating rapport.....	20
2.3.2 Resolving field issues.....	21
2.4 Finding participants.....	22
2.5 Data collection and storage	23
2.6 Data analysis	24
2.6.1 Intra-case analysis.....	24
2.6.2 Cross case analysis	25
2.7 Ethical considerations	27
2.8 Research rigor assurance	29

CHAPTER THREE: FINDINGS

3. Introduction to findings	32
3.1 The context – a description of participants and their workplaces	32
3.1.1 The workplace – mental hospitals in the Western Cape	32
3.1.2 The participants	33
3.1.3 The participants and spirituality at their workplaces	34
Summary	37
3.2 Emerging themes and categories.....	38
3.2.1 Theme 1: Clinical reasoning: complex, dynamic and multi-layered	38
3.2.1a Client centeredness precedes other considerations	39
3.2.1b Complex weighing up process	40
3.2.1c Critical check points	42
3.2.1d Context matters	43
3.2.2 Theme 2: Multiple resources: people as key	44
3.2.2a People	45
3.2.2b Information	47
3.2.3 Theme 3: Rewarding and challenging experience	47
3.2.3a Rewards.....	48
3.2.3b Challenges	49
Summary	49

CHAPTER FOUR: DISCUSSION

4. Introduction to discussion	51
4.1 Weighing up the inseparable science and art in occupational therapy	51
4.2 Considering narrative, ethics and practical issues	54
4.3 Thinking of the client as a whole	55
4.4 Negotiating the larger context for client centred occupational therapy	57
4.5 People as resource	58
4.6 The process of discernment as meaningful for practitioners	60
4.7 Rethinking occupational therapy in context	61
Summary	62

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion.....	64
5.2 Limitation to the study.....	66
5.3 Recommendations	67
5.3.1 Recommendation for future research	67
5.3.2 Recommendation for occupational therapy practice	67
REFERENCE LIST	69
APPENDICES.....	76
Appendix 1 (a): Ethics approval documents from University of Cape Town	76
Appendix 1 (b): Ethics approval documents from Stellenbosch University.....	78
Appendix 1 (c): Ethics approval from department of health, Western Cape	80
Appendix 2: Power point presentation for participant recruitment	81
Appendix 3: Information document and informed consent forms	85
Appendix 4: Interview protocol	88
Appendix 5 a-e: transcribed interview of all 5 participants.....	89
Appendix 5 a: Transcribed interview with Imani: 2010-01-19.....	89
Appendix 5 b: Transcribed interview with Jose	101
Appendix 5 c: Transcribed interview with Siya	115
Appendix 5 d: Transcribed interview with Sai	129
Appendix 5 e: Transcribed interview with Kris	147
Appendix 6 a – e: Stake worksheet 3 for intra-case analysis of all 5 participants.....	159
Appendix 6 a: Stake worksheet 3 for intra-case analysis of Imani	159
Appendix 6 b: Stake worksheet 3 for intra-case analysis of Jose	166
Appendix 6 c: Stake worksheet 3 for intra-case analysis of Siya	172
Appendix 6 d: Stake worksheet 3 for intra-case analysis of Sai.....	176
Appendix 6 e: Stake worksheet 3 for intra-case analysis of Kris	185
Appendix 7: Stake worksheet 4 for ratings of expected utility of each case for each objective	193
Appendix 8: Stake worksheet 5 A for matrix for generating theme-based assertion	194
Appendix 9: Stake worksheet 6 for multi-case assertions for the final report.....	198
Appendix 10: Researcher Journal	211

CHAPTER ONE

INTRODUCTION

1. Introduction to the study

For some years, amongst diverse professions, spirituality has emerged as a topic of considerable interest. Occupational therapy is no exception. This interest may be attributed to a growing awareness that there is a relationship between health and spirituality (Koss-Chioino & Hefner, 2006). Researchers from various disciplines have explored spirituality, including anthropologists (Koss-Chioino, 2006), religious leaders (McGrath & Newell, 2004), medical doctors (Kristeller & Hummel, 2006), nurses (Meyer, 2000), and occupational therapists (e.g. CAOT, 1997 as cited in Baptiste, 2005; Egan & Swedersky, 2003; Wilding, May & Muir-Cochrane, 2005 & Farah & McColl, 2008). However, there seems to be a gap between recognising that spirituality ought to be included in practice, and the extent to which it is integrated in reality, especially in psychiatry (Baetz, Griffine, Bowen & Marcoux, 2004).

Occupational therapy is challenged at this juncture in history to find ways of integrating spirituality within practice (Hammell, 2001; Egan & Swedersky, 2003; Johnston & Mayers, 2005). Such a challenge was intensified following the suggested central positioning of spirituality within the Canadian model of occupational therapy in 1997 (cited in Baptiste, 2005). Closer to home, in South Africa, there has been silence on the relevance and appropriateness of incorporating spirituality within occupational therapy practice. The current discussion on spirituality in occupational therapy has been dominated by Western notions (Wilding, 2002). For example, in Canada, Hammell (2001: pg 187) has explicitly recognised spirituality's ability to elicit and sustain "human volition as a basis for action" in mental health practice. It is puzzling that no such South African literature within occupational therapy is available for practitioners working in mental health, particularly as spirituality in South Africa is widely practiced among all racial and ethnic groups. It is the researcher's intention that, by engaging with the topic of clinical reasoning and spirituality within mental health in this study, such contextually relevant literature can be established for occupational therapists working locally. The current study will focus on the clinical reasoning process occupational therapists working in mental health settings in the Western Cape, South

Africa, undergo when discerning whether spiritual occupations that their clients engage in are health seeking behaviours or manifestations of their psychiatric illness.

1.2. Literature Review

1.2.1 Defining Spirituality

Spirituality is an integral aspect of health and wellbeing (Hawks, 1994). Although there is increased interest in it, there is not one universally accepted definition for spirituality. Having said this, it does not mean that common themes cannot be found amongst available definitions. The key feature regarding spirituality across health professions is that it connects an individual with the divine (or transcendent higher being), inner self or others and the environment (Schulz, 2008). Spirituality is defined by Schulz (2008: pg 264) as “ experiencing a meaningful connection to our core selves, other beings, the world, and/or a greater power, as expressed through our reflections, narratives, and actions, within the context of space and time”. McColl (2000) is in agreement with Schulz (2008), and offers additional descriptions for spirituality. Firstly, McColl (2000) describes it as a fundamental aspect of self which impacts on self image and identity (Schulz, 2008). Schulz (2008) views spirituality as a motivating force. Secondly, both Schulz (2008) and McColl (2000) connect the idea of a “source of meaning” to spirituality that is relevant to clients and therapists alike (McColl, 2000: pg 220). The workable combination of Schulz (2008) and McColl’s (2000) definition/description of spirituality has been chosen as the basis of this study. However, the current study only intend to makes use of the above combined definitions as a beginning point to which the participants’ own views and understanding builds on.

1.2.2 Spirituality as positive health seeking behaviour

According to Hawks (1994), spiritual health can be seen through internal or external traits of beliefs and behaviours. Hawks (1994) has reasoned that a spiritually well person has a coherent worldview that is consistent with his or her lived practices in society. Subsequently, spirituality gives those who are spiritually well a purpose in life, connection with others, a positive expression of self as well as experience of transcendence (Hawks, 1994). Contrastingly, those who are spiritually ill often orientate

their lives around practices that have little or no regard for others or their own health. Examples of such unhealthy practices are addiction and indulgence. These practices could put one's health at risk (Hawks, 1994).

Fisher, Francis and Johnson (2000) have expanded on the idea of different traits leading to unique behaviours for spiritual health; they have suggested six categories of such thoughts on a scale that they created to assess healthy spiritual behaviours as depicted in the table below:

Personalists e.g mediator	Individuals who believe their spiritual wellbeing is brought about entirely from their own human spirit. They look internally for motivation, to seek meaning, purpose, and values in life.
Communalists e.g. act of services & volunteerism	Communalists need to have harmony between themselves and those around them. Hence, they value quality inter-personal relationships that transcend morality and culture. It is important for them to have their meaning, purpose, and values clarified and lived out.
Environmentalists e.g. Earth child	Environmentalists are individuals who are in tune with nature as they have an appreciation of the personal and communal domains.
Religionists e.g. Church goers	Religionists are individuals who embrace the transcendental domain for their spiritual wellbeing. Their primary spiritual pathways are through their relationship with higher beings (e.g. God). These individuals' relationship with higher beings have a profound effect on their senses of identity and destiny, their relationships with others and the environment (Robinson, 1994, p. 3; Jennings, 1997, p. 7, both as cited in Fisher, Francis & Johnson, 2000).
Existentialists	Individuals who score highly on all scales except for the religionists. These individuals are concerned with themselves as spiritual beings, as well as the people and environment around them. However, they do not resonate as much with the idea of having a relationship with a transcendent higher being.
Globalist	Those who score high on all scales.

The above table illustrates that different individuals within the six categories seek to engage with their spiritual health in different ways depending on how they construct meaning through their lives, whether it is as individuals (Fisher, Francis & Johnson 2000) or more collectively.

A third option of viewing spiritual wellbeing is explored in a book titled 'Complementary and alternative treatments for spiritual and mental health' (Lake & Spiegel, 2007). This text explores practices which are believed to be able to restore, maintain and promote health. Examples of such practices are yoga, qigong (Chinese physical and mindful exercise), religious beliefs, meditations and exercises (Lake & Spiegel, 2007). These practices are examples of what healthy spiritual occupations may be if they helped individuals to connect to what they identified with and promote health. In South Africa, there are many individuals from the traditional African culture that would turn to traditional healers for spiritual wellbeing (Case, Menendez & Ardington, 2005). This African traditional health seeking behaviours could also add great diversity to concepts about wellbeing. The findings from Case, Menendez & Ardington (2005) point to the potential role culture may play in defining what would be seen as spiritual occupations. Furthermore, culture may influence choices of health seeking behaviours as well as the nature of individuals' understanding of their illnesses (Case, Menendez & Ardington, 2005).

1.2.3 Spirituality as symptomology in psychiatry and the African traditional context

Spirituality has generally held a somewhat controversial place in the Western understandings of mental health and disorders. For example, psychoanalysis in the first half of the twentieth century has largely considered engaging in religious practices as delusional behaviours (Sims, 2003). People with mental illnesses who engaged in occupations of a spiritual nature were studied as if they were scientific objects that had unacceptable "symptoms" and "manifestation of mental illnesses" (Sims, 2003: pg 3). At the same time, Western societies, as well as some interpretations of Christian scriptures have had a history of equating madness to evil possessions (Sims, 2003). Hence, spirituality began to hold associations connected to sickness and largely became 'taboo' in psychiatry. It was not until the 1980s that the concept of spirituality began to be re-explored, not as pathology, but as something of value in psychiatry (Sims, 2003).

Although it is less of a taboo currently, spirituality remains a dilemma within psychiatry as behaviours are possibly classified as symptoms. However, the same behaviours in question can be interpreted very differently depending on what are acceptable and expected behaviours of clients based on their cultural background. Swartz (1998: pg 5) suggests that "... no human activity is free from cultural influence".

Therefore, culture has an enormous influence on how different individuals view mental health and how they seek health behaviourally. Subsequently, culture may predispose individuals to seek spiritual health in the different ways described above by Fisher, Francis & Johnson (2000) (refer to section 2.2). It is also true that mental health has largely been defined through Western culture. This is largely acknowledged today but there remains a gap in Africa between lived cultural experience and what may or should be considered to be acceptable behaviour by health professions or medical disciplines.

The current study is not primarily about culture, although the literature so far indicates that it plays an important part in how practitioners and their clients may define mental health and therefore the topic deserves more attention. A useful example to consider is the qualification process of a traditional medical practitioner (i.e. n'anga or chiremba) in Zimbabwe. N'anga/chiremba(s) believe that they inherit their healing powers through being possessed by the spirit of a dead relative or stranger, who themselves had such healing abilities during early adulthood (Gelfand, Mavi, Drummond & Ndemera, 1985). The possessions by such a spirit enable n'anga/chiremba(s) to speak a language that they themselves would not understand unless they are in a trance when they are able to heal or tell fortunes. This process of becoming a traditional healer is also observed in South Africa by Swartz (1998) in his book 'Culture and mental health: a southern African view'. Both Swartz (1998) and Gelfand, et al (1985) admit that these 'typical' events leading to the formation of a traditional medical practitioner may very well seem like a psychiatric illness. According to psychiatric symptomatology, the above behaviours can be translated into delusions, hallucinations or thought disorders. One wonders how South African occupational therapists deal with such polarising and opposing information from their knowledge on symptomatology and the local culture during their daily practice in mental health as the culture of the clients and Western medicine both influence how occupational therapists may do their work. It was hoped that an opportunity for exploring such dilemma would be opened by inquiring about occupational therapists' clinical reasoning processes in relation to the above in this research project.

1.2.4 Occupational therapy and mental health

Mental health issues are linked to an area referred to as psychiatry. Mental health and occupational therapy has had an interesting relationship since the beginning of the profession. The formation of occupational therapy as a profession has been preceded by philosophical leanings in the 1800s such as

the 'arts and crafts movement', 'moral treatment' and 'mental hygiene movement' (Ikiugu, 2007: pg 4). These approaches exposed the indignity with which people with mental illnesses were treated in institutions. As a result of this realisation, mental health institutions became one of the early areas where activities and crafts were used to improve the condition of the institutionalised people. The occupational therapy profession continued to develop from its early beginnings throughout the 20th century. In this section, there will be an overview of methods and modalities used for their mental illnesses by occupational therapists.

Theories of mental health and illnesses influence how occupational therapy in this area is practised currently. The range of theoretical and philosophical foundations includes humanistic, biological, psychodynamic, behavioural and cognitive perspectives. The ultimate goal is to promote holistic care for those who use the mental health services in ways that protect them and their communities. This type of care is to be provided while trying to give the individuals as much autonomy as possible in different stages of their illnesses. Occupational therapy can be viewed as a profession that seeks to actively engage "a client in meaningful occupations in order to improve or maintain occupational performance and quality of life" (De Witt in Crouch & Alers, 2005: pg 3). Occupational therapy is concerned with enabling occupational engagements that promote health and wellbeing (WFOT, 2004). It is a profession that views the human as an occupational being with a need (Finlay, 2004) for relative balance in occupations (Wilcock, 2006). Therefore in mental health, the emphasis is on occupational engagements that support a client's participations in different contexts (Cara & MacRae, 2005). Building on this basic premise within occupational therapy, it is believed that there are three important interventions that are required. Firstly, it is important to have a good therapeutic relationship with clients; secondly, therapeutic use of meaningful occupations as treatment modalities is sought and thirdly, the therapeutic use of groups and the group process is utilised (Ikiugu, 2007; Finlay, 2004).

Occupational therapy intervention for mental health issues begins with understanding how clients perform in their daily occupations. In order to gain insight of clients and their occupations, occupational therapists ask significant questions and observe clients' interactions and behaviours (Pitts, 2005). More specifically, occupational therapists assess clients' performance skills, patterns, contexts in which these occupations are performed, activity demands and client factors (Pitts, 2005). Occupational therapists then negotiate with their clients the aims they would work on together. The aims often focus around one or more of the following: acquiring new skills, reducing deficits and improving self esteem,

stimulating social interactions, better occupational balance as well as monitoring progress (Finally, 2004). Thereafter, different methods are selected to achieve those negotiated aims. Intervention methods used in mental health include health promotion, remediation, adaptation or compensation for optimal functioning and to prevent further disability (Cara & MacRae, 2005: pg 516). These methods are embodied in four intervention forms known as the therapeutic use of self, therapeutic use of occupations, consultation and education in individuals and group sessions (Cara & MacRae, 2005: pg 516). Furthermore, by combining the therapeutic use of self and activities with therapists' ability to reason clinically (Ikiugu, 2007; Crouch & Alers, 2005), a 'right fit' can be found between clients' current abilities and demands of activities in the environment in which they are performed. These tools are said to be valuable for ensuring a relevant occupational therapy for mental health issues (Ikiugu, 2007; Crouch & Alers, 2005; Finally, 2004). Clinical reasoning has been suggested as integral in ensuring best practice in occupational therapy that is client-centred, ethical and effective in the clinical settings. Politics (Pollard, Sakellarios & Kronenberg, 2009) and culture (Iwama, 2006) are said to have an influence on the clinical settings as well. The challenges of providing the best possible occupational therapy in diverse settings are experienced by occupational therapists worldwide in their clinical practice (Pollard, Sakellarios & Kronenberg, 2009; Iwama, 2006) and while in training (Kinsella, Park, Appiagyei, Chang, Chow, 2008).

As mentioned above, there are several tools and resources available to the occupational therapists practising within mental health. Firstly, there is the use of self as part of the intervention. The therapeutic use of self takes the shape of interpersonal strategies to enhance clients' participations. The aims of such interpersonal strategies are to establish rapport which enables collaboration and transparency during interactions with clients (Ikiugu, 2007). Examples of these interpersonal strategies used by occupational therapists include validation, setting limits, encouragement, advice, coaching, confrontation, reframing, interpretation, metaphors and reality testing (Cara & MacRae, 2005).

Secondly, occupational therapists use occupations therapeutically. There are a number of purposes for utilising occupations which include (1) helping clients to master new skills and knowledge, (2) structure their time more constructively, as well as (3) meeting their needs for expressions, productivity, pleasure and connections (Finally, 2004). Further, Ikiugu (2007) suggests that occupations that are used therapeutically can enable a bridge to be formed between clients' multi-layered external worlds and their current abilities through actions. When considering the use of occupations in the context of

psychiatry, occupational therapists have been alerted to the need to carefully consider their clients' culture. Culture is defined as "the set of attitudes, valued beliefs, and behaviours, shared by a group of people, communicated from one generation to the next via language and some other means of communication" (Matsumoto, 1994, p.4 cited in Laliberte Rudman & Dennhardt, 2008: pg 154) and also as a dynamic process whereby meanings are collectively and socially constructed (Iwama, 2006). It is from this perspective that Iwama (2006) expressed his opinion that culture is important to occupational therapy. Hence, culture would play a vital role in defining what is a mental illness experience as well as what occupations would be perceived to be meaningful (Ikiugu, 2007; Iwama, 2006; Finaly, 2004). Through validating and being sensitive to culture, the client-centeredness philosophy of occupational therapy is enhanced (Ikiugu, 2007). The spectrum of occupational therapy activities comprises a range of options such as task activities aimed at developing functional performance components, socialisation opportunities that encourage interaction and leisure, experiences that support and share communication, as well as psychotherapy. These are done individually or in groups seeking to express and explore one's feelings (Finaly, 2004: pg 54).

Thirdly, the therapeutic use of groups and its process is also important in occupational therapy within the mental health services. Groups are a time and cost effective way to consult, educate and treat more people with mental illnesses simultaneously and participants can benefit through learning from one another (Cara & MacRae, 2005). It needs to be acknowledged that groups are used by various professions with different purposes and processes. Common models of group therapy include psychoanalytic, humanistic, behavioural and cognitive behavioural (Cara & MacRae, 2005: pg 534). Occupational therapists have a unique focus on using occupation as a means or an end within their approaches to group therapy. The types of groups commonly used by occupational therapists in mental health services include task orientated groups, developmental groups, directive groups, neuro-developmental groups and other groups that are not purely occupational therapy such as psycho-educational, expression or leisure groups that still facilitate wellbeing using activities (Cara & MacRae, 2005). Typically, an occupational therapy group would have an introduction where the goal of the session is shared with the participants, a main activity and end with a conclusion regardless of the content of the group (Ikiugu, 2007). Cole (2005) cited in Ikiugu (2007) developed a seven step format to group work which include an introduction, activity presentation, sharing of experience, processing, generalising, application of topic discussed and summary.

In the African continent, mental illness is one of the more common challenges that face the occupational therapy profession. It is also among the more serious conditions occupational therapists see (Alers & Crouch, 2010). Common mental illnesses in Africa include psychosis, paranoia, psychosis resulting from general medical conditions such as brain infections or damage, epilepsy, HIV and malaria. It can also be induced by alcohol and substance abuse, post traumatic stress disorder and mental retardation (Okasha, 2002 cited in Alers & Crouch, 2010). These mental illnesses are perceived to be related to "...theories of causation of illness..." that are connected with "... issues on the natural, social, personal or spiritual level" (Alers & Crouch, 2010: pg 290). As pointed out by Swartz (1998), mental illness may be associated with "impaired social relationships, bewitchment or not complying with the wishes of the ancestors..." (cited in Alers & Crouch, 2010: pg 290). Hence, occupational therapy in the African context needs to integrate theories mentioned above (e.g. how to assess or provide intervention individually or in groups) with the larger background context of the clients' culture. It is because contexts affect the attitudes towards mental illnesses and resources or barriers therapists and clients face in the community (Alers & Crouch, 2010). From an occupational therapy perspective, mental illness expresses itself by affecting the individual's ability to participate fully in daily activities that inform different social roles (Alers & Crouch, 2010). The perceptions and reality of losing roles due to inability to perform daily activities may result in occupational imbalance (Wilcock, 2006). This occurs as clients lose some of their significant roles such as that of being a worker. Stigmatisation of the client (Alers & Crouch, 2010) and occupational alienation (Wilcock, 2006) may also result.

1.2.5 Spirituality and occupational therapy

Occupational therapy joined other professions on the discourse concerning spirituality in the 1990s'. Discussion within the profession resulted in more awareness about spirituality which led to its central position in the Canadian Model of Occupational Performance in 1997 (cited in Baptiste, 2005).

On the one hand, the centrality of spirituality in occupational therapy practice is acknowledged by therapists in theory and yet, as said earlier, it appears to be difficult to negotiate in practice. This is occurring in spite of many attempts to define, describe and clarify the very nature of spirituality (McColl, 2000; Unruh, Versnel, & Kerr, 2002; Schulz, 2008) as well as suggestions about how it may be approached (Egan & Sedersky, 2003; Farah & McColl, 2008). On the other hand, spirituality and its centrality within occupational therapy practice have met with some disagreement. Hammell (2001)

argues that it should be replaced by a clearer term such as 'intrinsicity', while Unruh et al (2002) and Collins (2007) advocate for the use of a term called "occupational identity". It can therefore be concluded that the current discussion on spirituality appears to be a somewhat contested terrain in occupational therapy globally. This is a challenge for local therapists who are potentially also faced with further dilemmas as mentioned above in the section on *Spirituality as symptomology in psychiatry and African traditional context*.

Although there seems to be no succinct pathway through this difficult professional terrain, attempts have been made by international authors. Literature can be loosely categorised into:

- 1) Defining, describing or reflecting on spirituality (McColl, 2000; Unruh, Versnel & Kerr, 2002; Schulz, 2008)
- 2) Potential modality in the form of prayer (Farah & McColl, 2008)
- 3) Experiences of therapists dealing with clients' religious questions (Egan & Sedersky, 2003) and experience of clients (Wilding, May & Muir-Cochrane, 2005)
- 4) Occupational therapy assessment for spirituality (Schulz, 2008)
- 5) Opposing voices to spirituality as the centre of the Canadian Occupational Therapy Model (Hammell, 2001; Collins, 2007, & Unruh et al, 2002)

If holism and client centred practice can be assumed to be core values of occupational therapy as suggested by Christiansen & Baum (1997), it would mean that occupational therapy interventions will differ depending on clients and context. Taking these assumptions into account, it means that having an exact definition of spirituality or its different manifestations is not essential, or even possible, given the variables. The current research moves away from precise definitions towards exploring the clinical reasoning process of therapists when they deal with clients and situations regarding spirituality. Occupational therapists have an in-depth training on enabling clients to 'do', 'be', 'become' and 'belong' through occupations (Wilcock, 2006). Occupations are vehicles to survival and health (Wilcock, 2006). Clients stand to lose much if occupational therapists are unclear on how to assist them in using spirituality as a meaningful means towards survival and health.

Learning from other health professionals working within mental health, nurses have done some research on assessing experiences of a spiritual nature as reported by their patients. Eeles, Lowe &

Wellman (2003) studied nurses in psychiatry assessing such experiences using evaluation criteria. The evaluation criteria were found to fall into four main categories, i.e. outcome, nature, context and explanatory modes about the experiences (Eeles, Lowe & Wellman, 2003). However, neither the relationships amongst these categories nor the origin of knowledge were explored. In other words, on the one hand, the categories themselves seemed to presume the ways in which patients engaged with spirituality in relation to their background. On the other hand, the categories seemed to be based on how practitioners understood spirituality. Such subjective understanding from the practitioners therefore influences how they engage with patients in the given context (Eeles, Lowe & Wellman, 2003).

It would seem from the previous discussion that occupational therapy may benefit from a greater exploration of the role of clinical reasoning in respect to spirituality. This is because clinical reasoning is a tool that may assist therapists in finding the right fit between their clients' engagements in a spiritual occupation and their environments. By exploring the role of clinical reasoning in respect of spiritual occupations, a number of objectives can be achieved. Firstly, these would be greater consciousness concerning spirituality as it is an integral aspect of health (Hawks, 1994) that drives occupational engagement (McColl, 2000). Secondly it may assist occupational therapists to equip themselves better with ideas about healthcare in which spirituality is a resource for promoting health or it is a risk that needs to be addressed. This might be particularly relevant in mental health in South Africa as it may help therapists in finding ways to evaluate and work with clients from diverse backgrounds.

1.2.6 Clinical reasoning in occupational therapy

Client centred practice is an essential philosophy in occupational therapy where the client is active in collaborating with the therapists in overcoming difficulties that he or she experiences (Christiansen & Baum, 1997: pg 511). Occupational therapists work with a great diversity of clients who require different interventions. In a study on terminal illness and verbal communication difficulty, McGrath & Newell (2004) found that clients valued the "gift of relationship" with their carers in everyday meaningful occupations. Farah & McColl (2008) also found that prayer can be appropriate within occupational therapy intervention depending on the therapeutic context. Therefore, the process (i.e. clinical reasoning) whereby therapists decide on suitable approaches for different clients is essential as it will

dictate the content of a particular occupational therapy intervention with a particular client where there may have been a spiritual dimension.

Mattingly & Fleming (1994) suggest that clinical reasoning in occupational therapy is similar to the ancient practical reasoning concept of Aristotle. It involves deliberations of acting to achieve the “best good” in a particular context for that client at that time (Mattingly & Fleming, 1994: pg 10-11). Indeed, occupational therapy’s historical developments from humanism/social justice and science/evidence based practice shapes our approaches to clinical reasoning. These two sides embodied themselves as ‘practitioner centred’ versus ‘patient centred’ practice in health care (Higgs, Jones, Loftus & Christensen, 2008). Clinical practice is made even more complex by therapists’ own beliefs and values, their work context and the particular client’s context. Hence, Higgs, et al (2008) asserted that more research is needed on such reasoning processes especially in the context of clients’ health status being uncertain. On that note, mental illnesses qualify for a space where uncertainty can be found as the health care team often has to be responsible for clients’ health when they become incapable of making decision as they are acutely psychotic.

All of the above dynamics affect occupational therapists’ reasoning when making clinical decisions. Theorists have differing opinions about how the clinical reasoning process operates for the health professions. Within the literature reviewed on the topic, there are two ends of the spectrum about this process (Cader, Campbell & Watson, 2005). On the one end, across health professions, clinical reasoning involves a cognitive process that distils information and matches patterns from experiences to a decision (Cader, Campbell & Watson, 2005). On the other end, professionals’ worldview, intuition and beliefs are also said to influence the clinical reasoning process within occupational therapy (Cader, et al, 2005; Chaffey, Unsworth & Fossey, 2010; Unsworth, 2004). Cader, et al (2005) went further to suggest that health professionals’ clinical reasoning process operates not only in the purely cognitive or intuitive modes but can also be a mixture of both. This was termed ‘quasirationality’ (Cader, et al, 2005). According to Cader, et al (2005), these modes of reasoning assist health professionals to recognise patterns presented by their clients and to infer the implication and meaning of such patterns by comparing current clients to previous ones. As health professionals engage with this complex course of action, sensory information is processed and used to tell a meaningful clinical story through its linkages.

In order to hold a certain amount of information in mind, the professionals may alternate between using cognition and intuition or oscillate between the two to make sense of the presenting situations of their clients (Hammond, 1996 cited in Cader, et al, 2005). Although both cognition and intuition are commonly used in clinical practice by health professionals such as occupational therapists, both processes have been found to bear limitations (Banning, 2007). While the cognitive end assumes people to be totally rational and that power dynamics do not exist within sensory information, the intuitive end runs the risk of cues being linked to the wrong decisions (Banning, 2007). Further, Banning (2007) suggested that both ends of the spectrum relied on an assumed accuracy and quality of sensory information which may not be perfect in reality.

In occupational therapy, the use of cognitive processes and intuition has both been reported on in literature. A mental tool that is commonly used by therapists to consider all the dynamics and options present in the clinical reasoning process has been described as the three track mind (Mattingly & Fleming, 1994; Higgs, Jones, Loftus & Christensen, 2008). The three tracks were subsequently developed further into different types of reasoning styles as below:

The different modes of clinical reasoning used by occupational therapists when making clinical decisions

(Boyt Schell & Schell, 2008; Higgs et al, 2008; Mattingly & Fleming, 1994):

- 1) **Scientific reasoning** includes diagnostic vs. procedural reasoning to understand the impact of illnesses on the client (Boyt Schell & Schell, 2008; Higgs et al, 2008; Mattingly & Fleming, 1994). It is important to balance critical reflections with experience to result in sound scientific reasoning. For example, an occupational therapist could use cognitive assessment with someone who had a head injury to gain insight into the impact of the injury has on the client's occupational performance to predict the implication for the client's ability to return to work.
- 2) **Pragmatic reasoning** allows the therapist to focus on thinking about what is practical and achievable in the therapeutic context where they work with the clients and in relation to the clients' reality (Higgs et al, 2008; Mattingly & Fleming 1994). Boyt Schell & Schell (2008) further suggested that pragmatic reasoning is the reasoning mode that therapists use when faced with challenges from contextual factors that may facilitate or inhibit therapy. The above authors believed that two categories of factors (i.e. practical and personal context) require pragmatic reasoning (Boyt Schell

&Schell, 2008). Pragmatic reasoning in the practical context is concerned with “address[ing] the world in which therapy occurs” (Boyt Schell & Schell, 2008: pg 171). Contrastingly, “personal context” is focused on the therapists’ repertoire of therapy and negotiation skills, ability to read the practice culture, personal norms and attitudes. Examples of such practical and personal context factors include organisational norms, limitation of time, physical resources, case load, reimbursement for services, discharge options and the skills of the therapists (Boyt Schell & Schell, 2008: pg 177). For example, a private occupational therapist is restricted by the fact that his or her client’s medical aid will only cover six sessions when priorities of interventions are negotiated.

- 3) **Narrative reasoning** involves understanding and appreciating situations, leading to interpretations and therapy actions. Since interpretation is required, thus the belief and assumptions systems of an individual come to play a powerful role in this type of reasoning (Ballou Hamilton, 2008; Higgs, et al, 2008). Ballou Hamilton (2008) described this mode of reasoning as a process of making sense, collaborating to co-create clients’ future using storytelling and story making with clients. Within this mode of reasoning, therapists try to instill hope, encourage clients to find revisions to the life story, assist in reforming positive identity in spite of the experience of illnesses (Ballou Hamilton, 2008). Ballous Hamlton (2008) also highlighted the challenges of attentive listening with regards to narrative reasoning. The challenges described included considering the truthfulness or discrepancies in stories clients tell therapists, transference and counter transference of emotions between clients and therapists (Ballous Hamlton, 2008). For example, occupational therapists would ask clients to tell them about their past and hopes for the future to have a sense of why is the client in need of occupational therapy now and how the intervention need to be structured in order to facilitate clients in reaching for the future they hoped for.
- 4) **Ethical reasoning** is the process whereby therapists prioritise one set of beliefs or values over another for the better good when considering their clients. The basic principles of ethical reasoning include autonomy, beneficence vs. non-maleficence, justice and relationship principles such as veracity (the obligation to tell the truth), fidelity (obligation to keep promises and contracts to reasonable expectations) as well as confidentiality and privacy (Kanny & Yarett Slater, 2008). For example, an occupational therapist who’s treating a child with burn wounds noticed signs of abuse. He or she must consider his or her professional responsibility towards protecting the child from harm and take the appropriate action in response to this observation.

- 5) **Interactive reasoning** requires 'personal intelligence' in two different ways – 'intrapersonal' and 'interpersonal' (Boyt Schell & Schell, 2008). Interactive reasoning is shaped by the occupational therapists' worldview and values (Unsworth, 2004). The intrapersonal aspect needs the therapist to be able to reflect on his or her feeling and its implication for behaviours that are expressed due to these feelings. However, the interpersonal aspect of this style demands the therapist to be able to read the others' emotions, feelings and motivations. This has been noted to be a style of reasoning that is used particularly by occupational therapists who work in mental health settings (Chaffey, Unsworth, & Fossey, 2010; Ward, 2003). Boyt Schell & Schell (2008) suggested that interactive reasoning is an important tool when therapists attempt to share power with their clients in client-centred therapeutic relationships. An example of interactive reasoning would be occupational therapists could sense discomfort and silence when interviewing their clients and the family together at times. Through the reading of such dynamics between clients and family, the OT could ask to speak with them separately in order for more information can be gained from the interview.
- 6) **Conditional reasoning** issued when the therapists and clients engage in "reinventing" clients through the projection of the possible future, reflecting about the goodness of fit between the person and his/her environment as well as potential conflicts. Actions are then taken after having judged the soundness of decisions made (Mattingly & Fleming, 1994). Conditional reasoning was suggested as unique to occupational therapy as it takes "the whole condition" of the person, illness and context into consideration (Boyt Schell & Schell, 2008; Mattingly & Fleming, 1994). Conditional reasoning is a complex one to give an example. If one take a specific area of work rehabilitation to give an example, an occupational therapist need to consider the client's ability after the onset of a condition or the injury, the demand of the work, the supportiveness and insight from the employer and significant others, client's willingness to return, accessibility of equipments or suitable transport required in order to decide on how to approach the issue of employment with the client. Therefore, these considerations would direct occupational therapy interventions to differ from person to person.

1.3. Purpose and rationale of the study

There is limited research on how occupational therapists working within mental health settings discern whether occupations of a spiritual nature are health seeking behaviours or a manifestation of psychiatric illnesses. Therapists who are sensitive to diverse spiritual expressions through occupations could contribute towards a more appropriate occupational therapy practice within a South African context where diverse cultures and traditions exist.

1.4. Research Question

What is the clinical reasoning process used by occupational therapists in mental health settings in Western Cape, South Africa to discern whether occupations of a spiritual nature are health seeking behaviours or manifestations of a psychiatric illness?

1.5. Aim

To describe the clinical reasoning process occupational therapists in mental health use when determining whether occupations of a spiritual nature are health seeking behaviours or manifestations of a psychiatric illness

1.6. Objectives

To identify the key elements within the clinical reasoning process participants employ when they determine whether occupations of a spiritual nature are health seeking behaviours or manifestations of a psychiatric illness.

To identify resources from which participants draw on in order to inform their clinical reasoning process

To describe the experience of participants as they made decisions on whether their clients' engagements in occupations of a spiritual nature are health seeking or a manifestation of psychiatric illnesses.

To explore underlying knowledge, ideologies, beliefs and values that may have influenced participants' clinical reasoning process with regards to spiritual occupations of their clients.

University of Cape Town

CHAPTER TWO

METHODOLOGY

2. Introduction to methodology

This chapter describes how the study's research framework was selected and undertaken. Herein, several aspects of the methodology will be illustrated. To begin, the rationale of adopting a qualitative research approach will be explained. Then, the process of selecting the suitable methodology will be described. Within the selection process, a discussion on how a multi-case study design came to be the chosen method will be detailed. The research process (including participant selection and recruitment, data collection and analysis), ethical consideration and the assurance of research rigor will be discussed thereafter.

2.1 Qualitative research approach

Considering the element of subjectivity in spirituality through the perspective of postmodernist and social constructivism, it was felt that in the current study, multiple versions of its reality would be possible (Creswell, 2007). Following this perspective on reality, the complexity of the context in South Africa needs to be considered as well. It was understood that interpretation of the phenomena of interest could be influenced by the beliefs and value systems of researchers who might be unaware of existing ideologies shaping their understanding (Friesen, 2008). Thus, *reality* could only be understood in the context within which participants found themselves (Arocha & Patel, 2008). Seeing that subjectivity seems to be the key in this study, there are two research paradigms that are worth considering beside the obviously objective positivist paradigm which is link to quantitative research methodologies. The two paradigms are namely the subtle realists and the interpretivists. While both paradigms acknowledge reality is seen through human subjectivity, however they differ in their ideals and approaches towards exploring reality. The subtle realists still strive for objectivity while interpretivists celebrate diversity as they believed in social constructivism and meaning is created by parties involved (Guba & Lincoln, 1994).

In respect to the research question, this study sought to understand the identified phenomenon of how therapists decided whether occupations of a spiritual nature were health seeking behaviours or a manifestation of mental illness. Given the diversity of therapists, their workplaces and clients, qualitative research was convincingly more suitable. This was because multiple realities and space for alternate understandings could emerge. Further, to deepen the understanding of the phenomenon, the researcher also wanted to learn about the factors influencing in this process. In other words, the question of what were the underlying knowledge, ideologies, beliefs and values needed to be asked. Hence, diversity would be welcomed in this study as the interpretivist paradigm suggested. Additionally, ideology critique would be helpful in this regard as it could destabilise the unquestionable 'common sense' knowledge with its own power dynamics, social and political influences (Friesen, 2008). Having decided to take a qualitative path, selection of methodology based on the nature of the research question amongst the approaches available needed to occur. They were namely narrative analysis, phenomenological analysis, ethnography, grounded theory, single or multiple case study approach (Creswell, 2007).

2.2 Multiple case study design – confirming suitability

According to Arocha & Patel (2008), previous researches on clinical reasoning had followed three pathways, i.e. the "thinking aloud protocol", "retrospective protocol" and "explanatory protocol". As the current study aimed to focus on the elements within the process of clinical reasoning and their relationships to one another, it fell under the explanatory protocol category (Arocha & Patel, 2008). For this category, the participants (i.e. occupational therapists working within mental health institution) would be asked to 'explain' cases they had dealt with and this would be accomplished by the researcher in an interview format. Working from a postmodern and poststructuralist position in which language would be the main carrier of meaning, participants' explanations had to be recorded as it would be important to examine them closely in the data analysis process. Seeing that the study seeks to create a map of connections amongst the data, the strictly descriptive narrative and ethnographic approaches were not suitable (Creswell, 2007). Similarly, experience-rich phenomenology would also be inappropriate (Creswell, 2007). A multiple case study design was preferred as the researcher aimed to understand the multiple realities of the phenomena. A grounded theory was also not selected due to

the researcher's limitation in time and resources posing the risk of not arriving at sufficient data saturation.

A multiple case study approach had been defined as: "the study of an issue explored through one or more cases within a bounded system" (Creswell, 2007: pg 73). In this study, it involved an exploration of multiple bounded systems (cases). Creswell (2007) suggests that this can be achieved by doing in-depth data collection from multiple sources (e.g. observations, interviews, audiovisual material, and documents and reports). The outcome would be a report on the different case descriptions and case based themes (Creswell, 2007). In the current study, the system was bounded by place (i.e. Western Cape), context (occupations of spiritual nature within mental health services), persons (occupational therapists and their clients) and limited time of the research. In order for the subjectivity of human experiences to be acknowledged, participants would also be asked about how they experienced the process of clinical reasoning about spiritual occupations. The researcher believed that this would add extra depth to case descriptions in the given context. Hence, it should strengthen the case study approach as mentioned above (Creswell, 2007).

2.3 Research process (Creswell, 2003; Fontana & Frey, 2008)

2.3.1 Gaining permissions and creating rapport

Ethics approval was obtained from the University of Cape Town (reference no. REC REF: 292/2009 – see appendix 1a), Stellenbosch University research ethics committee (reference no. N09/10/278 – see appendix 1b) and the Western Cape department of health research committee (reference no. 2009 RP 84 OT- see appendix 1c) prior to the commencement of the study. Ethics approval and permissions from the above institutions were necessary as the participants' workplaces are provincial mental health services that were academically linked to the Universities of Cape Town and Stellenbosch. After permission was granted, the researcher contacted the heads of the occupational therapy departments in the four provincial associated psychiatric hospitals in Cape Town, South Africa. The purpose of the contacts was to arrange a time to do a presentation (see appendix 2) for occupational therapists in these workplaces. This participants' recruitment activity was done in staff meetings in the different workplaces. After the presentations, time was made available for clarification and questions. An information sheet about the study accompanied by the informed consent document (appendix 3) was

given to potential participants (i.e. occupational therapists) to decide if they would like to participate. Potential participants were given one week thereafter to indicate whether or not they were willing to participate. The consent sheets were either personally collected by the researcher or returned to her in sealed envelopes via heads of departments to ensure confidentiality of the decisions. A deviation occurred to the original plan as the current study did not utilise academic lecturers to recommend potential participants as proposed initially. This decision was made based on the fact that enough participants were found via the participants' recruitment presentations at the different mental health hospitals.

2.3.2 Resolving field issues

Janesick (2004) highlighted several relevant field issues applicable to this study. These issues include (1) peer review during data analysis, (2) final report production, (3) ensuring researcher to spend equal amount of time in the field, analysis and making data accessible to participants and (4) to handle potential changes in the field.

Related to the issue of peer review for the study, the researcher attempted to gain peer review in both the study formulation and data analysis phase via different means. For the study formulation phase, the researcher presented the study's protocol to the school of health and rehabilitation sciences, University of Cape Town and clinicians from one of the research sites for comments and suggestions. For the data analysis phase and final report production phase, a non-participating occupational therapist was asked to review the data analysis and the final report for credibility and clarity. The peer was asked to be critical in his or her comments about the data analysis and the final report. A deviation had occurred for obtaining peer review as the researcher decided to ask an occupational therapist instead of a professional from other disciplines to assist. This was done to enhance appropriateness of the peer to do the reviewing. Member checking was done after data analysis and peer reviewed to ensure the true representations of participants in the report. The researcher intends to make the final report accessible to participants electronically. In addition, the researcher kept a research journal to document observations and changes during the study process as suggested by Janesick (2004).

2.4 The process of finding participants

Purposeful sampling was regarded as suitable (Creswell, 2007; pg 125) and rigorous (Hansen, 2006) for conducting qualitative research. It allowed the researcher to choose purposefully the persons and places that would offer more understanding of the phenomenon under study (Hansen, 2006). Agreeing with the above, Stake (1995) also advocated for studying cases that maximise potential for knowledge in case study researches.

In order to do as Stake (1995) had suggested, the researcher needed to find participants with experiences in making decision regarding occupations of a spiritual nature. The underlining assumption was that years of experience would be related to the likelihood of having had such experiences. After considering the mixed opinions about the sample size of case study within existing literature, it was originally decided that the study would have four participants (Creswell, 2007; Stake, 2006). The researcher contacted the head of departments of the four hospitals in the associated psychiatric hospitals in the Western Cape and presented to all the staff at an arranged time as part of a staff meeting. Information sheets and consent forms were given to all potential participants at the end of the presentation. They were given a week to indicate whether or not they would like to take part in the study. The completed forms were either personally collected by the researcher or returned to her in a sealed envelope. From this process, it was uncovered that only five therapists were interested in taking part in the study. The study had five participants as one more occupational therapist than required was willing and suitable to participate. Since more participants meant more data could be collected to help understand the phenomena, the researcher decided to deviate from the original plan of having a sample of four most diverse and willing participants as only five therapists were interested in the study. The availability of only five willing therapists meant that choosing the four most diverse therapists and snowballing principle was excluded as it turned out that only one therapist was interested in each of the four institutions approached (except one institution where there were two interested).

In order to confirm whether the willing therapists were eligible to become study participants, they were evaluated against the following criteria. Eligible participants had to be:

- Occupational therapists currently registered with the Health Professional Council of South Africa (HPCSA).
- Working with clients with psychiatric illnesses in the Western Cape, South Africa for at least the past two years.
- Occupational therapists who perceived that they have dealt with spirituality issues in their clinical practice at least in three different incidences.
- Occupational therapists who have had experienced clinical reasoning around issues of spirituality.
- Occupational therapists that was willing and able to be interviewed more than once in the research process.

Note: in keeping with leaving all the results in the finding section of the report, the researcher decided to include the description of the five participants in chapter 3 instead of at the end of this section: findings as they are the context from which the data were collected.

2.5 Data collection and storage

Primary data were collected through semi-structured interviews (see appendix 4) where open ended questions were asked. Guiding questions were designed while bearing in mind the different types of open ended question categories as suggested by Janesick (2004: pg 72). The categories were descriptive, follow up, experience or example, simple clarification, structural or paradigmatic questions and comparison or contrast questions (Janesick, 2004: Pg 72). Although the interview questions would related into the study's objectives, they were not to be specific as space needed to be allowed for participants to respond freely in order for truth to unfold. Each participant had one interview with the researcher for approximately sixty minutes and a thirty minutes member checking session were also used to validate data analysis done. Secondary data collected were contextual information and sources of primary data that have informed the participants' decision making process with regards to their clients (e.g. mission statements, policy, protocols, public documents, the theories or continued professional development programmes that they may have drawn on). Thirdly, suitable data came from the researcher's journal that recorded observations and personal reflection about the study process. This process of collecting data from multiple sources was known as 'data source triangulation', which will be discussed further in the rigour session later (Stake, 1995: pg 112).

Interviews were recorded on a digital voice recording device. Then, they were transcribed per verbatim into electronic text documents which were identified by pseudonyms. These transcribed interviews became the documents used for data analysis. The electronic documents containing the interviews were then stored in the researcher's computer and were password protected. Both the computer and a backup copy in a flash drive were secured in a locked cupboard that was only accessible to the researcher.

2.6 Data analysis

2.6.1 Intra-case analysis

In order to allow themes and categories to emerge from every case without presumptions; each transcribed interview(appendix 5 a - e) was read through to identify similar quotes to form groups of like data following the step by step guide below by Creswell (2007):

Data management	Data files were created and organised
Reading and memoing	Researcher read through text several times before making any margin notes contributing towards initial codes. Janesick (2004) suggests that attention should be paid to where the tension is amongst the data.
Describing	A case description along with its context was written for each case (see chapter 3.1 on the context).
Classifying	Categorical aggregation was used to establish themes or patterns within each case before moving onto cross case analysis. Therefore, as the researcher read through the interviews, any segments of data in every case that seemed worth noting were highlighted and labelled into 'nodes'. The nodes identified were then considered in relation to each other within a specific case to establish any connection and meanings amongst them. This action resulted in a larger map of interconnected nodes for each case.

Interpreting	After the researcher obtained a map of interconnected nodes for each case, attention was then paid to identifying the dominating themes. Comments with regards to themes were recorded on Stake's worksheet 3 for individual case report (see appendix 6 a-e). These comments were then taken into account before and while researcher engaged with cross case analysis as suggested by Friesen (2008). Specifically, the researcher looked closely for instrumental/technical, practical/interpretive and emancipatory knowledge (Friesen, 2008).
Representing and visualizing	The findings were presented using descriptions, verbatim quotes and tables as seen in chapter 3. Such presentation of data was supported by Janesick (2004) as a mean to present study findings.

Note: Analysis software 'NVivo' by Richards, (2008) available from the Department of Occupational Therapy, University of Cape Town was used during the intra-case analysis.

2.6.2 Cross case analysis

After the intra-case analysis was completed for all five cases, Stake's (2006) method of multi-case analysis was used to generate themes and categories across cases. The rationale for utilising Stake's (2006) method was that it offered a systematic way to generate themes across qualitative cases using worksheets. A brief description of Stake's (2006) five worksheets used in this study can be seen in appendices 6 to 9. Please note: worksheet 1 was excluded as it was meant for planning the study which was already done at the current study's proposal stage:

Worksheet 2	<u>Research questions of the multi-case study:</u> This worksheet asked the researcher to outline the basic direction of the study. Hence, it was concerned with the study title, research question and aim as well as its objectives. A deviation was made from Stake's idea that objectives were themes as the researcher did not want to presume what might emerge from the data. Note: it is not included in the appendix as the same information had been detailed in chapter one where the research question, aim and objectives were discussed.
--------------------	--

Worksheet 3 (appendix 6 a-e)	<u>Analyst's notes while reading a case report:</u> This worksheet focused on summarising the intra-case analysis on each participant. Several aspects about the case were documented on this worksheet. These included description of the participant, his or her workplace, the activity at the workplace, contextual information and situational constraints. Due to confidentiality issues, identifiable data (e.g. name of institution) were omitted. Additionally, the prominence and expected utility of the case towards the identified objectives from worksheet 2 were ranked by the researcher. Lastly, possible excerpts for multi-case report and comments from the researcher were recorded at the end. This worksheet was used for all five participants in the study after the intra-case analysis was done as described in section 2.6.1.
Worksheet 4 (appendix 7)	<u>Ratings of expected utility of each case for each objective:</u> All the prominence and expected utility ratings from each participant's worksheet 3's were taken and arranged in a table on worksheet 4. Each case then further received ratings on any additional categories that emerged during the process.
Worksheet 5 (appendix 8)	<u>Matrix for generating theme-based assertion:</u> Stake (2006) gave three options on this step of cross case analysis. Option one was chosen as it was the most detailed and qualitative orientated option amongst the three available. As instructed by Stake (2006), the researcher completed this worksheet in the following way: <ol style="list-style-type: none"> 1. All findings from the five participants were written on paper cards (Stake (2006) refers to them as 'finding strips'). The cards were then shuffled and sorted in the order of importance in relation to a particular objective. The findings that were rated of high importance in the sorting process were given a score of 'three' on the corresponding block on worksheet 5. Those with medium importance were rated with a 'two' and 'one' for those with low importance. 2. A parenthesis was then added to show whenever a case was indicated as prominent in worksheet 4 or had high expected utility in worksheet 3s for different objectives into the respective corresponding blocks on worksheet 5.

	<p>3. After the two steps described above, the researcher read through the worksheet and marked any atypical cases against every objective with an 'A'.</p> <p>4. Then, the researcher returned to the finding strips. The findings were ranked of importance towards a particular objective from step 1 based on their usefulness towards understanding an objective. An 'assertion by bypass' was then generated by making a concluding comment after reading through the most useful 4-6 findings. This process was done for all objectives with its respective findings seen on worksheet 5.</p> <p>Before completing worksheet 6, the researcher analysed the resulting assertions (i.e. themes) and categories in relation to the different objectives in an iterative manner in order to ensure no repetitions or omissions occurred.</p>
Worksheet 6 (appendix 9)	<p><u>Multi-case assertions for the final report:</u> This worksheet presented systematically, in a table format, the plan towards generating the final report. Taking each assertion (i.e. the themes) generated in worksheet 5, supporting verbatim quotes were taken from different cases and recorded next to the corresponding categories within each assertion. The completed worksheet 6 was then used as a guide when writing about the study findings (see chapter 3).</p>

2.7 Ethical considerations

Ethics need to be considered throughout the process of research (Creswell, 2007). For this study, the four common ethical principles (Philpot, 2004) and Emanuel et al (2004)'s eight principles for qualitative research were combined. Emanuel et al (2004) suggest eight principles of ethics in qualitative research as follows: 1) collaborative partnerships, 2) social value, 3) scientific validity, 4) fair selection of study population, 5) favourable risk-benefit ratio, 6) independent ethical review, 7) informed consent and 8) ongoing respect for participants. The above principles can be embodied in research studies through ensuring fair sample selection, informed consent and confidentiality (Emanuel et al, 2004). These ideas were applied to the current study by using the four common principles as headings (Philpot, 2004). See details of the combined ethical considerations below:

Respect for autonomy: This principle refers to the participants' right to have freedom of choice. An emphasis on the voluntary nature of participants' involvement was clearly stated on the information sheet and informed consent (appendix 3). The informed consent was designed according to Roberts & Roberts, (1999)'s suggestion: 1) to give information, 2) explicit respect for autonomy and 3) to have a space for them to express their decision about participation. Potential participants were assured that they may discontinue at any point in the study when the researcher presented to them. Participants' choices were respected throughout the study process (ongoing respect for participation) (Emanuel et al, 2004). Respect was maintained through e.g. making appointments at a place and time of participants' choice and member checking with individuals to ensure they were satisfied with the quotes used.

Non-maleficence: This principle refers to a favourable risk and benefit ratio in conjunction with the principle of beneficence (Emanuel et al, 2004). Although few risks were associated with participants being interviewed, the researcher cautiously observed if any emotional distress occurred. Although it did not occur in this study, if it had, the researcher would have discontinued the interview immediately and referred participants to appropriate professionals for confidential counselling. Secondly, in order to reduce identity risks, data were stored in a secured manner (see 'recording and storing data' as above). Further, names of workplaces were removed and pseudonyms were assigned to participants to ensure their confidentiality. Finally, data collection only began after permission was granted from the independent research committee based at the University of Cape Town, Stellenbosch University, and the Western Cape provincial department of health.

Beneficence: This principle refers to the benefits associated with participation. Firstly, the final research question in the current study was arrived at by having collaborative discussions with occupational therapists working in mental health services to confirm the usefulness of the focus of the study. Secondly, relevant literature was reviewed to ensure its validity for inquiry. This was done to enhance the study's social value and scientific validity. In addition, participants were made aware of the fact that there were no direct personal benefits or remuneration for participation even though the profession as a whole could benefit from their contributions. However, some participants might perceive the opportunities to speak about their experiences relating to the topic of study during interviews as

beneficial as they considered their own clinical reasoning process in relation to spiritual occupations of their clients.

Justice: This principle referred to fairness for participants in relation to the burden they bore by agreeing to participate against the possible benefits. Potential benefits of the current study could be new understanding of clinical reasoning about spiritual occupations within the mental health context. To enhance benefits from the current study, participants were purposively selected to maximise opportunities to explore the phenomena. Additionally, member checking was done to ensure true representation of participants in the final report. For the participants, the potential benefit of having an opportunity to reflect on their own practices and access to new contextually appropriate literature (Note: participants would receive the final report electronically) was considered along with the potential risk of being identified and experiencing distress during interviews. As discussed in the section on 'beneficence' and 'non-maleficence', although the risks were limited, strategies such as the use of pseudonyms, password-secured storage of data and referral to counselling resources were used to ensure a fair ratio between the benefits and risks that could be experienced by participants.

2.8 Research rigor assurance

In qualitative studies, it is the trustworthiness of the research process and design that makes a study rigorous (Hansen, 2006). The purpose of ensuring rigor is to promote quality and real data from the current study (Hansen, 2006). In this section, four areas of trustworthiness are discussed. They are credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985). According to Hansen (2006), triangulation, respondent validation, purposeful sampling, method, analysis transparency and researcher reflexivity are often used to strengthen a study's rigor. These strategies are discussed below in relation to the different aspects of ensuring research rigor for the study.

- 1) Credibility** could be compared with 'internal validity' in quantitative research. In this study, it was concerned with the integrity of this study. An attempt towards credibility for this study was done through doing peer reviewing at the designing, data analysis and report writing stages as suggested by Stake (2006). The peer was encouraged to find 'faults' and discuss implication of the findings

(Stake, 2006). Additionally, an attempt on presenting the study design's details accurately with contextualised data was done as recommended by Creswell (2003) to enhance credibility.

- 2) Dependability** related to issues about the “suitability of methods, and transparency of methods and analysis” (Hansen, 2006: pg 49). As described in chapter two, the researcher underwent a systematic process to devise the study's methodology. Hence, it could be regarded as dependable in the designing phase. Further, in order to ensure dependability in the execution of the study, the researcher followed the implementation plan as per the research proposal and record any adaptation with its justification in the research journal as a transparent audit trail of decisions as suggested by Long & Johnson (2000) and Hansen (2006).

The data analysis process could also pose different dependability issues. The researcher developed a protocol for triangulation while consulting literature as follows:

Protocol for triangulation

1. Data sources triangulation: data was collected via 3 different ways (i.e. direct interviews, examination of supporting documents provided by some participants and reflection of the researcher). This was done to validate its truthfulness across different situations and levels towards thick descriptions of the cases (Stake, 1995: pg 112 & Stake, 2006).

2. Reflexivity of the researcher meant that there should be a constant process of self-examination of the researcher's own position in relations to whom she was researching about (Pitts & Smith, 2007). The researcher kept a research journal as suggested by Fontana & Frey (2008) and Long & Johnson (2000).

3. Quote per verbatim was done rather than interpretive text as it reduced the chance for biases, assumptions or reality distortion (Hansen, 2006). Particular attention was placed in the data transcription process to achieve this. The researcher listened to the interview several times before transcribing per verbatim and then once again after transcription to check its correctness. More attention was then paid to quote per verbatim as the researcher selected quotes for the final report.

4. Negative case analysis –all variation of the phenomena under study was embraced by reporting diversity of participants' views and experiences. This process helped to improve the understanding of emerged concepts (Mays & Pope, 2000).

5. The use of a systematic method towards cross case analysis: Stake (2006)'s worksheet orientated method towards cross case analysis were used to enhance the dependability of analysis.

6. Member checking (Long & Johnson, 2000; Stake, 1995: pg 115): When data collection and analysis were completed, the researcher met with the participants again to have their opinions on the "accuracy and palatability" of the study's findings. The participants also checked each quote from their interviews to give permission for its use in the final report. The member checking process also allowed the researcher to confirm that participants felt they were truly represented by the current study's findings.

7. Data presentation in a model: Through identifying patterns in the data, themes that developed were presented in a visual model to discuss the relationships between cases. This was the last step of conducting a case study as according to Creswell (2007).

3) Confirmability refers to a complex aspect of trustworthiness. It requires the researcher to maintain a relatively neutral position and to avoid distorting the reality within the context from which the study was done. The researcher engaged in a reflective process during the analysis process by writing in a research journal as an attempt to maintain such a neutral position (Hansen, 2006). Where appropriate, extracts from the research journal was included in the final report (see appendix 10).

4) Transferability speaks about the degree to which the findings can be applied to other settings. Although qualitative findings are rarely generalisable, they should be understandable and recognisable (Hansen, 2006). In other words, the reader needs to decide if the findings are relevant for their contexts. Thus, in order to achieve this in the current study, an attempt in reporting the research context, methods, sampling and findings clearly was done (Lincoln & Guba, 1985). Visual aids in the format of tables in chapter 3 and diagrams in chapter 4 were also used to enhance the clarity further.

CHAPTER THREE

FINDINGS

3. Introduction to findings

In line with the philosophy of qualitative case study design, this study valued the multiple realities from which the data emerged. This chapter will begin with a description of the context of the workplace. The chapter continues with an exploration of the three themes with their associated categories that emerged in the study. They are namely (1) clinical reasoning: complex, dynamic and multi-layered, (2) multiple resources: people as key and (3) rewarding and challenging experiences.

3.1 The context – a description of participants and their workplaces

3.1.1 The workplace – mental hospitals in the Western Cape

Within the health care system in the Western Cape, there is a three tier system of care. One component of this system focuses on mental illnesses. It is known as the associated psychiatric hospitals (APHs). The APHs consisted of four specialised psychiatric hospitals, specialised children and adolescents units based in tertiary hospitals and two step up/down facilities where the aim is to reduce the need of inpatient admissions. The services provided by the APHs speak to diagnoses such as schizophrenia, bipolar disorder and personality disorders; intellectual disabilities and substance abuse related mental disorders for adult and children etc. According to the Department of Health (Provincial Administration of the Western Cape (PAWC) (1999: pg 7), these hospitals' overall functions are to provide "specialised inpatient mental health care and rehabilitation for adults and children who cannot be managed at other levels of care". The focus of care has moved from the previous custodial focus to rehabilitative care (Department of Health (PAWC), 1999: pg 7). Due to policy changes, community based mental health services are more preferred (Lund, Kleintjes, Kakuma & Flisher, 2010). Hence, the number of beds and the average length of stay in these hospitals are on a downward trend (Lund, et al, 2010). At times, crisis discharges due to bed pressure become unavoidable in spite of the fact that this increases the longer term risks of readmissions (Niehaus, et al, 2008). This has ripple effects on occupational therapists working in these hospitals, and directly affects the study's participants in the time they have for each

client. Subsequently, it affects the chance for participants to consider the spiritual dimension in their practice.

3.1.2 The participants

The five participants occupied clinician and/or managerial positions in the occupational therapy departments across the four associated psychiatric hospitals in the Western Cape. They ranged in age and years of experience. In terms of age, participants ranged from twenty seven to forty eight years old in this study. They had a range of experience from two to seventeen years. Many in the sample were Cape Coloured and Indians in ethnicity. Their religious backgrounds were Muslim, Apostolic Christian and Hindu. The demographical description of the five participants is summarised in the table below:

Table 3.1: demographics and workplaces of participants

	Demographics	Type of psychiatry experiences
Imani	36 years old, Muslim, female, 15 years of psychiatry experience.	Sub-acute therapeutic unit for adults.
Jose	29 years old, Hindu, female, 3 years of psychiatry experience.	Acute adult psychiatry.
Siya	48 years old, Muslim, female, 17 years of psychiatry experience.	Acute psychiatry, sub-acute therapeutic unit and step down community therapeutic unit for adults.
Sai	27 years old, New Apostle, female, 2 years of psychiatry experience.	Acute psychiatry for adults and adolescents unit.
Kris	37 years old, religion not identified, female, 13 years of psychiatry experience.	Long term psychiatry for adults.

The participants' workplaces included acute admission services, sub-acute therapeutic units for adults and adolescents as well as long term services. The responsibilities ranged from one to four wards, with a varying population from 12 to 145 clients. In the therapeutic units, participants were case

managers. This differed from those who were in the acute or long term units where the quantity of clients demanded for a population approach. Despite the diversity in settings, common trends in occupational therapy in mental hospitals could be found. In essences, it was the finding of a 'right fit' in groups or individual therapy for clients that were important. This meant that participants would take a stabilisation focus using basic activity groups initially e.g. music, art and crafts progress towards the more discussion based life skills, goal setting and introspection groups. Additionally, when it was appropriate and possible, prevocational rehabilitation or supported employments opportunities were provided to clients. Further, when time and resource permitted, some participants also did social events and home visits for their clients.

3.1.3 The participants and spirituality at their workplaces

With regards to spirituality, all the workplaces of participants had some degree of discouragement or avoidance on the discussion of religion despite the staff might be religious or spiritual individuals themselves. The main reasons given were firstly to avoid religious conflict and secondly to avoid the possibility of exacerbating clients' psychiatric symptoms. This was seen in the following quotes by Jose and Kris:

Jose: "...when we have a group, we stay away from the religious because once it starts it goes on and on and on... and because we have a mixed group, ... So to avoid the politics we keep it out as a subject."

Kris: "in that insistence I would definitely not encourage discussion around their religion and their beliefs because I feel like it just bring out more thoughts..."

Even though there seemed to be influences towards avoiding discussion about religions, discrepancies were observed. Christianity was found in the wards. For example, while attempting to increase the accessibility of religious options, Kris observed a Christian dominance at her workplace. This was seen in the following quote:

Kris: "At the moment that Christianity is a very big force in this hospital, in fact the only one. So we haven't explored partnership with different religions."

Similarly, Sai also observed the limitation of such lack of diversity; as seen in the following quote:

Sai: "it's a particular prayer in English that everybody prays. There already ...I don't think we are discriminating but.. already we don't all pray the same thing. So, even if I am a Muslim I must pray this prayer because it's part of the ward program."

Despite the above avoidance, discouragement and discrepancies; participants acknowledged that spirituality is an important issue in therapy. Therefore, although it might be avoided in groups by some participants, all participants dealt with occupations of a spiritual nature on an individual basis. However, they also expressed that it was not common to consider this aspect of the clients within their teams in the workplaces. Sai commented on how mental health professionals related to spiritual matter in their workplaces as below:

Sai: "I think maybe there was ways but there was no space ...for it that we as a staff didn't look at it."

Having said that, examples of spiritual occupational engagements in groups were still given by in Sai and Kris's interviews that emphasised introspection and nature respectively.

Sai: "...the psychologist, what we have done is besides him; it came out that point in time that different members in the ward had, u know, same things about... he was questioning this spirituality and religion so we decided we would have a group, the two of us; around it. So there was space created now to talk about things that came up whether you Muslim or..."

Kris: "...one small example would be we had an outing one day we went and spend 5-6 hours at Kirstenbosch ...afterwards we came back we sat on the lawn and we had a group umm and it's just peaceful and quiet... and trigger a lot of previous memory of them being in touch with nature and all of those memory were positive."

In addition to the context in which participants worked, their views and descriptions on spirituality also influenced how they worked with their clients' engagement in spiritual occupations. Agreed by all participants, spirituality was a connection to a person within themselves or to an external source. Jose, Siya and Sai believed that spirituality was a set of values that motivated people to live particular lifestyles. Hence, spirituality as motivating forces guided one's connections with self, others and the world. An example was offered by Siya as follows:

Siya: "it's an internal sense of purpose that I gain from my sense of being, who I am and how I am in the world and how I am with others ...and the values that I hold, all part of how I see myself as a spiritual being."

Specific connections with a higher being were also frequently mentioned. Sai gave an example of such connection in relation to herself as below:

Sai: "For me, being spiritual is connecting with ... my religion [that] guides me. It's where I connect with my God..."

Further, participants acknowledged that religion (connection to higher beings) appeared to be important to most clients. Religion in this manner however does not necessarily equate to spirituality as found in this study. It can be seen in the following quote from Kris.'

Kris: "Spirituality is not religion and religiosity is not spirituality."

Furthermore, they pointed out that other connections were possible, even though they seemed less frequently seen. An example was offered by Jose in the following quote:

Jose: "If you look at our catchment areas, ... where drug is prominent and low functioning people uneducated people [live]. So it's very rare that you would see like a high functioning with like an Earth child person..."

What was interesting and relevant to the study was that some participants described the existence of a 'fine line' between psychosis and spirituality seen in their workplaces. Participants offered several perspectives on this 'fine line'. On the one end, Siya believed that all occupations have the potential to be spiritual. On the other hand, the occupations' potential to give or prohibit health and spirituality as depended on the clients' mental state as illustrated by Siya's quote below:

Siya: "Because they already becoming ill, so they can't see right from wrong. [It is] not the occupation itself [that is health giving or not]."

Occupying the middle ground, some participants expressed that health seeking and psychosis based spiritual occupations are not necessarily mutually exclusive. In fact, the two properties may coexist in some cases as follows:

Kris: "...he was sitting in a multidisciplinary team [ward round] and he's started talking about his connections and the powers how he get messages from certain plants. And then the whole team was discussing that he was clearly psychotic.... And it is true, there is.. he is thought disordered and psychotic but at the same time I could see that it was meaningful..."

Beside acknowledging the 'fine line', Kris went a step further to state her belief that spiritual occupational engagements have to be linked positively to meaning and health for it to be considered a spiritual occupation as indicated by the quote below:

Kris: "Umm ... well u see then I would not classify it as spirituality if I am talking about someone who is completely psychotic and religiose. I wouldn't classify that as a spiritual dimension that had made this person ill."

Summary

From the above discussion, there were many similarities among the participants, they all had been raised within religious traditions, although these varied. They also all worked in an overburdened system, with a high patient turnover and limited resources. Diversity was also noted in several aspects. Firstly, there was a variety of the target populations the participants worked with in terms of the acuity and type of mental illness. Therefore, services provided across the workplaces differed. Each participant therefore faced both common and unique challenges as occupational therapists in their workplaces. For example, the high turnover and volume of clients meant less time during admissions. Secondly, the participants were diverse in their age, years of experience, cultural background as well as views on spirituality and its significance for clients across practice settings. Amongst the participants' views on spirituality, a variety was observed. On the one end, one participant believed that all occupations have the potential to be health giving and spiritual, depending on the client's mental status. On the other end of the spectrum, another participant believed that spiritual occupations must possess health giving characteristics by definition. In between these two ends of the continuum, other participants felt that health giving spiritual engagement and symptoms of mental illness were not mutually exclusive. Therefore, the above commonality and diversity influenced what participants considered as occupations of a spiritual nature and how they integrated those occupations in practice.

3.2 Emerging themes and categories

This section of chapter three presents the three final major themes that emerged through cross case analysis from the five participants in this study. The three themes are as follows:

- Clinical reasoning: complex, dynamic and multi-layered
- Multiple resources: people as key
- Rewarding and challenging experience

The resulting themes seen above were developed through an iterative process of making connections between data and combining them into categories and themes. This process was aided by using Nvivo software and Stake's (2006) cross cases analysis worksheet 3 – 6 as described in Chapter 2: Methodology (see appendices 5 - 9).

3.2.1 Theme 1: Clinical reasoning: complex, dynamic and multi-layered

All participants described elements of a multifaceted clinical reasoning process as they spoke about their clients. A more comprehensive version of this process became clearer through the data analysis. The table below shows theme 1 in an overview:

Table 3.2.1 Clinical reasoning: complex, dynamic and multi-layered

Categories	Sub-categories
Client centeredness precedes other considerations	Tension between biomedicine and OT philosophy Meaningfulness & implication for engagement Curiosity Desire to understand client Respect and openness Client's voice matters
Complex weighing up process	Observation Appropriateness & consistency

	Weighing against clients' own perspective Person's narrative against norms Benefit & harm
Critical check points	Is it a spiritual occupation? Is it health giving? Is it a symptom? Is the client ready to engage? What does my gut say?
Context matters	Limited resources for adolescent psychiatry Straight forward symptoms Limitation on OT scope within program Preference for team as resource Environment outside (nature and workplace) Implication of clients' engagement for the ward environment Rules in the ward

3.2.1a Client centeredness precedes other considerations

Amongst the participants, client centeredness was highlighted in different ways as an important issue. It appeared to be a major driver that directed participants' prioritisation of information from and about the clients. Client centeredness manifested within participants as an attitude of openness as illustrated below:

Sai: "we need respect for that even though we dealing with psychotic clients here, we still need to consider that that is still part of that person's life."

This led participants to desire an appreciation of meanings and reasons behind the specific spiritual occupational engagements. Two examples below illustrated how two participants tried to understand their clients' Islamic and Rastafarian beliefs in practice respectively:

Imani: "the first thing that was done by the MDT (multidisciplinary team) to say that, you know, to understand why it is that they need to wear the full keejap (face scarf)..."

Jose: "why they do what they do because obviously they don't do what we do. We have a lot of the patients with the long nails and refuse to cut it and big hair ... they were dirty so I needed to understand why ..."

Although the clients' perspective was important to the participants, Kris warned that one needed to take careful consideration of what was meaningful to clients in order to be truly client centred. In some cases, it might have little to do with spirituality. This was suggested in the following quote:

Kris: "Umm so I take each person's meaning and experience of meaning... and then some will have spiritual implication and I will draw on it from there."

In addition to the caution towards achieving true client centeredness, participants were also alerted to other factors that required one to be mindful of. One such factor was the potential tension between biomedicine and occupational therapy philosophies. This factor was illustrated within Kris's description of one of her client attending a ward round below:

"Yar, very stable umm interesting actually, I would say stable and okay. But he came to visit us in the ward round the other day, he was sitting in a multidisciplinary team and he's started talking about his connections and the powers how he get messages from certain plants. And then the whole team was discussing that he was clearly psychotic.... And it is true, there is.. he is thought disordered and psychotic but at the same time I could see that it was meaningful..."

3.2.1b Complex weighing up process

Although client centeredness was expressed as important, there were more revelations about the process from the analysed data. As participants described how they dealt with cases they experienced, the complexity involved was uncovered. To describe it simply, it involved 'weighing up' multiple factors that were gathered or observed in relation to a client's perspective and the implications of their engagements. Two persistently mentioned aspects were the appropriateness and consistency of the engagement across context and time. The two quotes below showed such considerations in action:

Jose: "it all sounds delusional because like the women with the outside water only, it all comes from the same source so it wasn't bore hole water, it was just outside."

Sai: "...because in OT, ...and it didn't only happen there when you asked about the Bible we spoke about. It also happened in psychology also."

The weighing up continued after the consistency and appropriateness of the spiritual occupations were examined. Going one step further, the clients' occupational engagements were also examined in parallel with their pre-morbid behaviours. Thereafter or simultaneously, participants also added their clients' cultural and societal norms into further considerations. See examples below of such comparisons:

Jose: "...how were they coping and like ever since they used gunja[marijuana] what happened and like basically how they stay their day, I look at if it's more balanced or not."

Imani: "...a woman does dress up in full keejap but she still does not act modestly that this dress is suppose to imply then there's something else going on."

Taking another turn in the process; the clinical reasoning process continued as participants considered all the above in relation to the clients' own views and the implications of the particular engagement as seen in the following quotes:

Imani: "he was there to seek help ... not necessary to provide a service ... would it be right for him (client was a minister) to be providing that service [counselling to others]?"

Sai: "but changing in terms of music and clothing is a different part to changing like Shane (not real name of the client) being gay or something..."*

One may wonder how did the participants managed to consider multiple complex factors altogether. This was particularly fascinating if one considers that there were many other factors that influenced decision making besides client centeredness as shown in table 3.1. In dealing with this complexity all participants seems to be helped with the tool of observation, in order to monitor their clients' progress by looking at behaviours, thoughts and speech patterns. Observations occurred in the wards, in groups and on individual basis. Observations about the clients were compared with collateral from families, other team members and the clients' own perspectives as well. Below is an example of how observations helped participants' clinical reasoning process:

Imani: "as you observe people in their practice, if they are consistent... .. it is more likely to be true to what they would do in a healthy state but it is that inconsistency, you know, that lead you to question whether the expression of spirituality is an expression of ... or whether the behaviour is a expression of true spirituality or whether is part of a psychosis ...".

3.2.1c Critical check points

In the previous section, it was suggested that the clinical reasoning process about occupations of a spiritual nature were complex. If the clinical reasoning process was as multifaceted as described above, one wonders, how did participants engage in this process while also responding to other demands in their workplaces? Imani and Sai spoke about a few critical check points that helped them to distinguish the health giving occupations of a spiritual nature from those that indicated illness more rapidly.

Firstly, Imani was alerted to the fact that one needed to understand the occupation in question. Questions about whether the occupation was spiritual were asked. In addition, if it was indeed an occupation of a spiritual nature, then whether it was healthy or symptomatic was to be explored as illustrated in the following quote:

Imani: "it goes hand in hand to decide whether the behaviour is appropriate or whether it is suitable spiritual ... not suitable spiritual ... but Whether it is a spiritual expression that could indicate a psychiatric illness or whether it is just their ways of expressing themselves."

The readiness of clients to engage in occupations (spiritual or not) was mentioned as another check point by Sai as follows:

Sai: "[When] he was admitted, he was really psychotic, disorganized speech, he couldn't really engage in a conversation. He would talk about blue he would talk about black ... he need to be stabilized before he can engage..."

However, in order to arrive at a workable conclusion; something else was needed. Imani had an interesting view regarding this. Imani described it as 'the model of my gut' in the following way:

Imani: "...my whole philosophy [is] if it works for you and it's working for the people around you and.. or it's not interfering with the people around you then it's okay."

3.2.1d Context matters

The discerning process did not occur in isolation between just the client and the therapist involved. It occurred in multidisciplinary teams where other health professionals, clients and their significant others contributed as well. Hence, as the name of this category suggested, the context in which the clinical reasoning occurred mattered. It had the potential to influence the result of such a process as it might influence the occupational therapists involved.

Interestingly, participants who worked in acute settings where there was a rapid turnover of clients articulated that spiritual occupations were often due to symptoms as the acuity of clients' illnesses were expected to be high. Hence, the fast moving nature of the acute settings led to a preference of people resources within the team. Two quotes below by Jose captured both these aspects nicely:

Jose: "Most of it was part of the illnesses and not health seeking".

Jose: "I use them [OT colleagues] to... if I feel that I am not entirely satisfied with the answer that I got here [within the multidisciplinary team in the unit]."

Contrastingly, sub-acute specialised therapeutic units had a different picture. Due to the specific focus of these programs, some participants expressed frustration towards the limitations experienced by them as occupational therapists. Additionally, literature was perceived to be less available for the client population concerned in some situations. An example can be seen in the below quote:

Sai: "...for adolescents it is quite different to find articles specific to what you specifically dealing with in the group. There are no books and I think the same they learn from one another the same we learn from one another."

Another picture came to view in the longer term settings as well. Unlike the acute settings where the clients were unlikely to be out of the hospital while admitted, longer term clients could have opportunities to experience spirituality in different environments through different occupational therapy interventions. Kris gave two examples as follows:

Kris: " ... one day we went and spend 5-6 hours at Kirstenbosch (botanical garden in Cape Town)... and afterwards we came back we sat on the lawn and we had a group umm and it's just peaceful and quiet, the view is fantastic and everyone was peaceful in touch with nature and trigger a lot of previous memory of them being in touch with nature and all of those memory were positive."

Kris: “there is one lady who’s very much encourage religious, like before they start their day everyone gets together they stand in a circle, somebody says a prayer, it can be anybody any kind of prayer. It can be an Islamic faith or if you are from a Christianity base. Somebody will pray in the group before they start their day. And for her, it is a positive motivation to get everybody ready for the day, a very peaceful frame of mind.”

In this situation of ‘context matters’, unique challenges and opportunities have been explored in relation to different contexts. The participants described how these challenges and opportunities existed within the multi-disciplinary team, as well as working with clients in a group. Within the diversity, two common concerns were shared explicitly by all participants. Firstly, any decision has to be made within a given set of rules and regulations in the workplace. Secondly the clients themselves must observe and respect the larger community in the hospital setting, particularly in respect to other clients’ rights in terms of the implications of their individual engagements in their spiritual occupations. The quotes below provided a window into the situations:

Imani: “It is very debatable whether cannabis is good thing or bad thing for one’s mental state ... if [it is] good for you when you doing it in the ward ... someone else who it may be bad for may be encouraged by what you do...”

Jose: “As a rule, from what I have seen with the patients who are grandiose whether it is Christian or Muslim or whatever; we.. when we have a group, we stay away from the religious because once it starts it goes on and on and on...”

3.2.2 Theme 2: Multiple resources: people as key

As participants in this study spoke about the process of dealing with occupations of a spiritual nature in their clinical practise, they identified the resources that helped them. The following table summarises the two main types of resources that emerged from the interviews with participants:

Table 3.2.2 Multiple resources: people as key

Categories	Sub-categories
People	The occupational therapist Clients Team members Collateral from significant others Activity facilitators Employers
Information	Literature Internet Organisation

3.2.2a People

People were identified as an important resource by all participants. In order for a decision to be made during the clinical reasoning process, the participants and client(s) involved were core in guiding the direction of the decision. However, the decision making could not be done without the help of other team members and clients' family members. Additionally, employers and volunteers were also mentioned to have had enabled spiritual occupational engagements.

To participants such as Imani, Jose and Kris, the therapist's lived experience and ability to observe helped them in the clinical reasoning process. Examples of how experience and observation helped them can be seen in the following quotes:

Imani: "I think ...it's also where I come from and what my life experience is umm... that's hopefully had made me a little more open minded...about spirituality"

Jose: "when everyone say she's stable she's not talking too much, energy level lower and I saw how she engage in the group [and] one on one, with good eye contact and made a lot of sense."

However, the participants did not make conclusions solely, because the clients of whom it concerned also played a role in guiding towards a conclusion. Clients provided the direction and feedback to the participants. This was seen in unison amongst the participants in the following two example quotes:

Imani: "Because it is sometimes it is a belief that ... it is not necessarily the fact ... is it really the way things should be [and] go back to ... why you (clients) think this is the way things should be?"

Sai: "The patients at the end of the day became my resources."

Outside of the duo of client-therapist relationship, team members and significant others were also found to be resources. They were said to assist by providing information and collateral, seen as follows:

Jose: "we spoke to our Xhosa women around here ...and they told us no they do go through rituals but ...and they compare what her behaviours to what she was doing what she was saying and they say no this is not right..."

Sai: "...but when the parents came and confirm and said that he is but it's not dagga it's belonging to them [Rastafarian]"

Additionally, activity facilitators and employers provided an enabling space for clients to engage with occupations of a spiritual nature. The following quotes illustrate how this is possible:

Kris on activities facilitators: "I have also seen some of our volunteers in our group work, you know what they bring as a person. ... That as individual people, they are extremely spiritual in their own way umm the one draws on energy source and the other one draws on meditation and that captures the attention of our clients ... and I found that it is more than just doing the pottery then and it's more than just doing the yoga activity."

Kris on employers: "Now, the person he works with, he's also very much a spiritual person umm and he's extremely in touch with nature and getting energy from nature. So the relationship between the two of them are dynamic, because they just clicked."

3.2.2b Information

People in the participants' workplaces played a significant role in the clinical reasoning process. However, there were times more knowledge or information would be required for a better understanding of their clients' spiritual occupational engagements. Three forms of information sources were identified. They were namely organisations, academic literature, and the internet as illustrated below:

Kris on literatures: "I have become a lot more conscious of it when I have studied my Masters so I don't know if it's an issue of being exposed to literature..."

Jose on the internet: "I haven't use textbooks for those two cases. I used Google."

Imani on organisations: "... for the Muslim client it would be the MJC (Muslim Judicial Council), to give them the legal advice to help with divorce procedures."

Furthermore, it is interesting to note that the variety of different sources of information helped the participants differently. This could be to do with their own preference of choices, or it could be dependent on accessibility, or the way the different contexts utilised information as resources. For example, while Kris explained how she found literature to be a helpful source of information, Jose used internet instead and found it equally of use to her.

3.2.3 Theme 3: Rewarding and challenging experience

Imani, Jose and Sai described their involvement in discerning whether occupations of a spiritual nature were health seeking behaviours or manifestation of illness as a mixture of rewarding and challenging experience. The participants own views on spirituality seemed to influence their experiences of the process. Kris, for example believes that spirituality is only positive; hence she had only seen rewards in her experiences. However, Siya's frustration with the limiting role of the occupational therapist in her setting led to a challenging experience. The table below summarised the categories and sub-categories that emerged from collapsing similar data together for the formation of this theme.

Table 3.2.3 Rewarding and challenging experience

Categories	Sub-categories
Rewards	Better understanding of client Witness clients improvement Diversity acknowledged Mutually beneficial
Challenges	Emotionally difficult Expected to be a cultural expert Different professions working together

3.2.3a Rewards

Participants attributed positivity to experiences of benefiting the clients involved. This experience of positivity can be a result of assisting clients both directly or indirectly. For Sai, directly observing improvement in clients was satisfying, seen as follows:

Sai: "...it's nice to see progress ... you would see a different feel of the client, it's more realistic topics that comes up."

On a different note, rewards could also come from helping other team members to understand clients. This was shown in the following quote:

Imani: "...you help them to understand what it could be that the client meant or where the client would be coming from."

Simultaneously, by helping other team members, Imani also experienced that a sense of acknowledgement regarding the diversity that existed in the multidisciplinary team. This was significant, particularly given the pre-1994 context from which South Africa had come:

Imani: "what was nice was that, ..it also highlighted the different background we came from and despite that one could get along ..."

Hence, the benefit of being able to assist or engage with discernment about the health giving or illness origins of spiritual occupations could be mutually beneficial for the clients, participants and team members involved.

3.2.3b Challenges

Although the participants had rewarding experiences as described previously, they also faced several challenges at different levels. On an individual level, as Sai explained, it could be emotionally difficult when one listens to clients' difficult life experiences:

Sai: "...at times I was emotional because I also needed to vent because their stories became very [traumatic]."

Challenges experienced on an individual level went beyond the emotional aspect. For Jose and Imani, it was also uncomfortable to be expected to have cultural knowledge as their teams looked to them for guidance with regards to clients that had similar cultural background as themselves. Some insight could be gained through Jose's comment on this matter:

"it's kind of unpleasant because ... I am not the expert ... I wished I had the answers but I actually don't."

Moving in the direction of interactions within the team, different challenges occurred for the participants in relation to other professions. For example, when Sai teamed up with the psychologist in response to their curiosities towards their clients' expressions of spirituality; different expectations from different professions posed a challenge as they worked together:

"I think it was difficult for different two professions. Because for me, you get the feeling the sense that now the group is tired and we need to stop now and the psychologist [wants to keep going] because there is more and more stuff coming out..."

Summary

An exploration of the three themes that emerged from the study were reported on in association with categories and illustrated by quotes. The clinical reasoning process involved to discern whether an occupation of a spiritual nature was a health seeking behaviour or manifestation of mental illness was described as a complex, multi-layered weighing up process. Although academic literature, internet and organisations were mentioned, people were found to be a key resource that assisted participants in the clinical reasoning process. People resources included the therapists, their clients, other team members,

significant others of the clients, activity facilitators and employers. Participants generally viewed the clinical reasoning process involved as a rewarding experience as they saw improvement and developed a better understanding of the clients for themselves or members of the multidisciplinary team. In addition, through helping others to understand clients' occupations of a spiritual nature, an acknowledgement of diversity occurred amongst colleagues as well. However, unrealistic or different expectations of participants by their team members could also create challenges and discomfort. Furthermore, it was also emotionally taxing to contain traumatic stories of clients as participants introspected while they engaged with a facilitated group as a collective spiritual occupation.

University of Cape Town

CHAPTER FOUR

DISCUSSION

4. Introduction to discussion

This chapter seeks to make meaning of the findings on clinical reasoning in relation to spiritual occupations within the context of occupational therapy mental health practice. The participants' process of distinguishing the nature of occupations of a spiritual nature by clients will be examined. This is intended to provide ways of understanding different aspects of the process that assist participants during their discernment of whether such occupations have been health seeking behaviours or manifestations of mental illnesses.

Firstly, the relationship between the scientific and humanistic facets of clinical reasoning is explored, as the researcher followed participants in their consideration of issues on narrative, ethical and practical considerations towards developing an intervention response. Secondly, ways in which participants considered their clients as a whole will be investigated in relation to understanding their clients within multiple environments. Resources used by participants and their experiences during the process will be examined as well. Finally, the researcher will take a closer look at the impact of the different contexts on a client centred approach in occupational therapy.

4.1 Weighing up the inseparable science and art in occupational therapy

Clinical reasoning in occupational therapy has been described as the 'three track mind' (Mattingly & Flemming, 1994). It has also been viewed as a range of cognitive styles (Boyt Schell & Schell, 2008). The tracks and styles include: scientific, diagnostic, procedural, interactive, narrative, ethical, pragmatic and conditional reasoning (Boyt Schell & Schell, 2008; Mattingly & Flemming, 1994). In the present study, all these tracks and styles were found at different points of the clinical reasoning process, while participants considered their clients' occupations of a spiritual nature. Furthermore, it was discovered

that the 'science-based' cognitive styles, e.g. the scientific and diagnostic styles, were inseparable from the 'art-like' interactive reasoning styles which focus more on the human aspects. The high degree of interaction that forms part of the process towards understanding clients with mental illnesses accounts for this inseparability (Ward, 2003). Such inseparability between the 'science' and the 'art' resonates with the definition of occupational therapy suggested by Townsend & Polatajko (2007: pg 372 cited in BAOT). Hence, as seen in this study, participants used scientific, interactive and procedural reasoning in a combined manner during the clinical reasoning process. For example, as participants weigh up the multiple factors in their clinical reasoning process, they considered their clients' illness and spiritual occupations' implication to their future health using their diagnostic knowledge. Similarly, by taking in clients' own accounts and being aware of workplaces contexts rules about spirituality, participants also paid attention to interactive and procedural reasoning. Regarding the inseparability of scientific versus humanist consideration in the 'weighing up' process, it would appear that participants were using a mode of clinical reasoning in which cognition and intuition have been integrated. Such a mode of clinical reasoning is known as *quasirationality* (Cader, Campbell & Watson, 2005). On the scientific side in this 'weighing up' process, practical tools have been observation skills, assessment, as well as gathering client's personal history from significant others, and knowledge of norms. On the humanistic side are intuition (Chaffey, Unsworth & Fossey, 2010) and worldviews (Unsworth, 2004) which are associated with the participants' lived experiences and attitudes of respect and curiosity. These skills have aided the process of integrated clinical reasoning.

To illustrate the dynamics in this 'weighing up' process and to aid explanation, a graphic image (see diagram 1 below) was developed. As depicted on the one hand of the scale, participants explored the scientific and diagnostic issues as they considered the appropriateness and consistency of clients' spiritual occupational engagements. In order to obtain more details, participants compared the appropriateness and consistency of engagements with cultural, developmental and pre-morbid norms of the particular client. According to the participants, this was a continuous process of comparison while they assessed, observed and collateral information. Simultaneously, on the other end of the scale, participants also listened to the client's own perspective, considered implications of the occupational engagement in question on the client, the clinical environment, and assessed the client's readiness to engage. In this way, humanistic qualities such as respect, openness and intuitive sensing were exhibited. 'Weighing up' between science and art while distinguishing between spiritual occupations that promoted health or represented illnesses mirrors the tension in the continuing conversation between pragmatism and structuralism in the occupational therapy profession (Hooper & Wood, 2002). The

pragmatist holistic view celebrates the agency of human beings. It therefore rejects viewing humans as “... anything less than their total experiences” (Hooper & Wood, 2002: 41). The pragmatist view in other words promotes a view of flexibility and context bound knowledge. Contrastingly, as noted by Hooper & Wood (2002), structuralism is interested in the static components of the human experience, with knowledge as absolute and certain. In light of the tension, it is interesting to note that participants’ ability to combine science and humanism is congruent with the belief that occupational therapists are capable of working with different reasoning styles in an inseparable way at different stages as required (Ward, 2003; Harries & Harries, 2001). Perhaps, it also points out the importance of both structuralism and pragmatism in the profession of occupational therapy – that they ought to be considered side by side, not separately. Below is a graphic illustration that describes the participants’ ‘weighing up’ process in action (diagram 1).

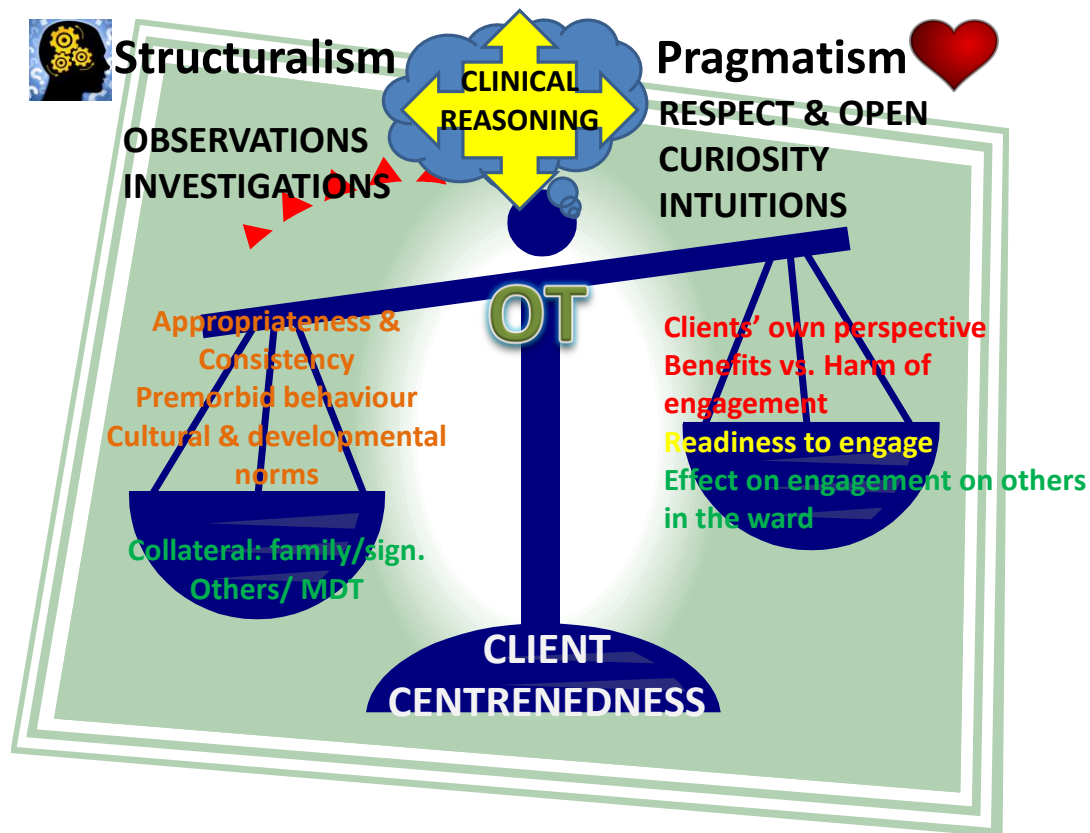


Diagram 1: The weighing up of the inseparable science and art in OT’s clinical reasoning

It needs to be noted that the weighing up is a process that happens backwards and forwards until a tentative decision is reached. Hence, the clinical reasoning process that participants used in connection

with occupations of a spiritual nature was non-linear. In fact, it required participants to consider multiple sources of information through comparisons. Such multiple comparisons of different information could be done through processes of 'oscillation' and 'alternation' where participants might have to switch focus between information and mode of clinical reasoning (Hammond, 1996 cited in Cader, Campbell & Watson, 2005). Such dynamic deliberation of information and perspective in the 'weighing up' process requires something fundamentally vital as an anchor. In the present study, client centeredness was identified by participants as having such a grounding importance. A more detailed discussion will follow later within this chapter about client-centeredness as the focus for an exploration of how participants considered their clients as a whole in different contexts.

4.2 Considering narrative, ethical and practical issues

As the focus moved away from the interaction between clients and participants at a particular moment and in a specific place and time, more aspects of the clinical story were considered by the participants within the process of discernment between manifestations of health or illness in occupations of a spiritual nature. Within the clinical stories as told in interviews (see appendices 5a-e), participants considered clients' current occupations of a spiritual nature in relation to the clients' narratives (both past and possible future). This was of particular importance as participants tried to decide how to approach the matter in a client-centred, ethical and practical way in the context of the therapeutic relationship. In the therapeutic interaction, narrative, ethical and pragmatic reasoning were employed to assist the participants.

Narrative reasoning was employed when the participants observed their clients across time and context to assess consistency of their occupational engagements. Furthermore, participants considered the implication to health from the occupational engagement as a vital aspect during the clinical reasoning process. In relation to narrative reasoning, it appeared that participants were concerned about how clients' current occupational engagements would impact their future in the different environments in which they would engage in occupations.

Having gained direction from the clients' narratives, participants sought to provide occupational therapy interventions that best fitted the particular individuals within practical constraints of the clinical environment. This brings attention to ethical aspects of the clinical reasoning process which took three

different forms in this study. Firstly, there were concerns about the benefit and risk associated with a specific occupation of a spiritual nature, consistent with the ethical principles of beneficence and non-maleficence. One participant (Imani) simply suggested that if the client was happy and the engagement was not harmful to him/her or others, then it would be fine. Therefore, respecting clients' autonomy was the second concern. Thirdly, reconciling conflicting values of structuralism and pragmatism also seemed to be an ethical issue. This conflict became intensified as participants weighed up multiple perspectives of clients and people surrounding them. Conflict of values between members of the multidisciplinary team are a common cause for ethical dilemma (Kinsella, Park, Appiagyei, Chang, Chow, 2008) and tension as expressed by participants in this study.

However, a further step was taken by participants as they considered how to practically navigate their clinical settings using pragmatic reasoning. This was because different clinical settings had different demands, types of clients with different mental states, resources availability as well as ward rules. All these factors in clinical settings had an impact on the focus, content and length of occupational therapy interventions that participants could engage their clients with. For example, participants who worked in acute admission unit settings felt that expressions of spirituality in occupational engagements were most likely to be part of clients' illnesses as their mental state was expected to be unstable. Contrastingly, in longer term settings, participants who worked there even had opportunities to use people resources such as volunteers, activity facilitators and supported employment placement supervisors in the process of distinguishing the health seeking behaviours and the manifestation of illness as well as providing interventions.

4.3 Thinking of the client as a whole

The complexity of considering multiple factors and perspectives in relation to clients, their occupations and their environments in terms of place and time played a role in contributing to another aspect of the clinical reasoning process. Such complex multiple considerations could be seen as the manifestation of conditional reasoning, where participants needed to consider the client, their occupations and environments as a whole. As participants took such a holistic view on their clients, they embodied the pragmatist value of human agency, hope and potential (Hooper & Wood, 2002).

Conditional reasoning is concerned with viewing the client as a whole (Mattingly & Fleming, 1994). In order to attempt to provide a clearer explanation of such a complex concept, a visual illustration of such process has been created (see diagram 2 below). As discussed in the previous two sections, participants needed to bear in mind the inseparable 'weighing up' of multiple factors (see section 4.1) while balancing their practise finely through considering narrative, ethical and practical issues (see section 4.2). In diagram 2, participants are represented by the figure which is shown to be thinking about the inseparable weighing up of both the scientific and humanistic factors. The thinking bubble contains a simplified version of diagram 1 to represent the active deliberation. In order to show that the nature of participants simultaneously considered narrative, ethical and practical issues relating to clients, the figure illustrated an analogy of balancing on top of an unstable stack of rocks to represent the dynamic and changeable nature of these issues in diagram 2 which follows.



Diagram 2: Thinking of the client as a whole

4.4 Negotiating the larger context for client centred occupational therapy

In this study, all participants stressed the importance of client centeredness in their clinical reasoning as they distinguished between healthy and illness represented by spiritual occupations of their clients. The importance of client centeredness was expressed in the participants' prioritised consideration of the clients' perspective, as Flannery, Wainwright & Quinn McGinnis (2009) also found in their study. Participants demonstrated attitudes of respect and curiosity about clients' occupational engagement. They seemed to go beyond taking a clients' perspective into account. Clients were actively involved as participants asked them to validate information and others' perspectives about themselves during the process of clinical reasoning. An attempt was made to share power with clients, enabling participants to examine the particular occupational engagement in question through a two-sided lens of meaning and implication. In such an examination through the two-sided lens, both the pragmatic value of the whole human experience and the structuralist concern for the systemic impact of the occupation of a spiritual nature were considered side by side. In their regular work in mental health care practice, participants often discuss clients in ward rounds with multidisciplinary teams. As illustrated by *Kris* in the study, ward rounds can be the environment in which tension could be felt between the biomedical culture and occupational therapy. This is partly due to their respective representations of structuralism and pragmatism in the ward rounds. In the present study, this stood out particularly when different members of the team read client's own explanation of their occupations of a spiritual nature through the two different perspectives. Often there would be a clash between the valuing of meaning from the participants' occupational view versus the biomedical symptomology view. The latter often assumed a powerful position within the multidisciplinary teams within which the participants discussed clients. The above tension in the study confirms that occupational therapy cannot be an apolitical profession as politics is everywhere (Pollard, Sakellariou, Kronenberg, 2009). Pollard, et al (2009) expand on the concept of politics, they emphasise the small 'p' politics in everyday occupational therapy practice which have nothing to do with political parties. In fact, it is rather about politics of everyday practice. In the present study, the tension felt by participants could be a fitting example of such small 'p' politics in mental health practice.

In addition, this tension experienced by participants was not only felt in ward rounds. The biomedical model influences the boundaries and rules that govern practice in the participants' workplace. The

inflexible nature of the rules described by participants suggested a structuralist foundation of the boundaries they experienced at work. Interestingly, this was often unspoken yet somehow known by all professionals involved. All participants mentioned how the 'ward rules' seemed to take an avoidance, discouraging or 'approach-with-care' stance on spirituality (particularly when it was expressed by clients in occupations linked to religious practices). Despite the unspoken rules, discrepancy was found. For example, religious symbols were present in the wards (Researcher Journal, 2010) and at meal-time, Christian prayers were said. It was also interesting to note that other religions never featured during meal-time prayers in this context. Hence, an inconsistency existed in this otherwise absolute rule, which pointed to the politics and macro influences that might have impacted on which client occupations of a spiritual nature were promoted and which were not. It was also interesting to observe how participants responded to such restrictions on spirituality. It appears as if participants were mindful of the restricting rules while also desiring to exhibit their belief in human agency, so they engaged in 'underground' practice (Mattingly & Fleming, 1994). This desire can be attributed to the pragmatistic aspect of the occupational therapy philosophy (Hooper & Wood, 2002). For example, *Jose* followed the 'absolute rule' about religion in group sessions as it helped to prevent chaos and potentially the triggering of psychotic symptoms. Yet in individual sessions, according to Jose, clients' spiritual occupational expressions were more accommodated and attended to. Such underground practice appears useful in negotiating the tension between pragmatism and structuralism as well as politics in participants' workplaces. It is a skill that can add to the cooperation and conflict strategies as suggested by Pollard et al (2009). Furthermore, such 'underground' practice maybe the in-between state that occupational therapists find themselves in until the opportunity is right for participants to either engage with cooperation or conflict(Pollard, et al, 2009).

4.5 People as resource

In this study, participants found themselves working with cases in their workplaces with varying numbers of people and information resources that assisted them in the clinical reasoning process. Ultimately, this helped with the distinction between the possible health giving spiritual occupations and opposed to those expressing symptom. People were key resources within this process. All participants spoke about the importance of enquiring and confirming their reasoning with different kinds of people. First of all, participants' use of self-reflection seemed to suggest that they used themselves as resources

too. Imani went further to suggest that internal elements such as 'lived experience' and intuition were also helpful in the process. However, such therapeutic use of self was moderated by input from clients which equally guided the clinical reasoning process. Secondly, participants took into consideration other team members' relevant cultural knowledge, opinion and observations about the particular client during ward rounds to validate their own observations. Interestingly, participants valued others within the same team more than their own occupational therapy colleagues. This was perhaps due to the context bound nature of discussion that needed to occur. In addition, it could also be that participants' workplaces had a culture of high turnover of clients, hence using those within the team would give a more immediate response than other occupational therapists who were not in the same environment even if they worked in the same hospitals. Such preferences as found in this study are consistent with the importance of accessing colleagues for assistance and supervision as found by Flannery Wainwright & Quinn McGinnis (2009).

In this study, it was interesting that participants did not only find colleagues useful as resources which were the case with Bannigan & Moores (2009) and Flannery Wainwright & Quinn McGinnis (2009). Depending on the context of their work, participants spoke to clients' family members, bosses and partners for collateral on clients' premorbidity and cultural norms and expectations. They also valued volunteers, activity facilitators and supervisors at clients' supported employment placements as resources in enabling clients to experience spirituality through engaging in occupations. Hence, this study suggests that different people are important in this process and that such people exist at all levels of the clients' environment – within the treatment team, in the wards and in their families and workplaces. The use of lay persons as resources seems to suggest that participants valued the interconnection between people. This is in harmony with the interdependent view of human existence that is linked to an African cultural belief known as Ubuntu. Ubuntu philosophy believes that "a person is a person through other persons" (Broodryk, 2006). This is an interesting alternative view of clients and people around them to both pragmatism and structuralism which are fundamentally about the individual. The Ubuntu view sees human existence as interconnected and interdependent and its view on people as resources seem to differ from the individualistic notion of human agency within pragmatism.

As mentioned above, information also played an important role during the clinical reasoning process. When participants needed more specific culturally relevant information, organisations were also used to gain insights into cultural norms and expectations. Participants mentioned that information sources

such as the internet and academic literature were also used. There was a low level of mentioning of academic literature, which confirms its position as the last resort as found by Flannery Wainwright & Quinn McGinnis (2009). In summary, there seems to be a model of prioritising the use of available resources: first using subjective experiences and observation skills, then the input from colleagues and the clients' significant others, and lastly information from knowledge bases such as the internet and academic literature (Flannery Wainwright & Quinn McGinnis, 2009).

4.6 The process of discernment as meaningful for practitioners

In this study, participants had different views about the nature of spiritual occupational engagements. One participant contemplated the possibility of spirituality occurring both in a client's healthy and ill states; another expressed the view that spirituality was meant to have only a positive impact on clients' health. However, participants agreed that the process of clinical reasoning about clients' occupations of a spiritual nature was often rewarding. It was particularly rewarding when participants got a better understanding of clients' perspectives and when they observed improvements in the clients. In addition, participants seemed to benefit in a personal way. For example, when they assisted other team members to understand clients' occupations of a spiritual nature, diversity amongst the team members was also acknowledged. Given the historical segregation due to Apartheid politics in pre-1994 South Africa, this seemed to possibly be a small way of people reconciling with one another. In the current study, perhaps such acknowledgment of diversity stimulated the connection between the participants and other individuals at work. Furthermore, when clients entrusted their traumatic experiences to participants while attempting to find a connection to their narratives, it touched the humanity within the participants as they empathised with their clients.

The experiences that participants had while working with clients to address occupations of a spiritual nature were not always positive. Listening to traumatic experiences could become emotionally straining for the participants. The challenges encountered were not only related to the participants as individuals. In Sai's case, it was also testing when different professions worked together on issues of spirituality in group settings, as expectations from different disciplines differed. Clear and open communication was mentioned to be helpful in such situations. The challenge continued when participants were expected to be cultural experts in their teams simply because they might have been the only team members from a certain background. Such expectations often caused participants discomfort. Participants attributed the

discomfort to the fact that they did not believe themselves to be experts or even know enough about the culture associated with their ethnic backgrounds. This feeling of 'not being an expert' might have two obvious reasons linked to the South African context as well as to a pragmatist view on knowledge. Firstly, in South Africa many previous generations came from all over the world. Hence, for example, if one appears to be Indian, it does not mean that that person has extensive knowledge about India if he or she is a third or fourth generation South African. Secondly, as mentioned in section 4.4, the importance of clients' perspectives are essentially in line with the pragmatist view that knowledge is bounded by context. Therefore, one can imagine that, even if one knew about a particular ethnic culture in detail, participants would still value the clients' perspective. Hence, participants' own knowledge about culture would only be used as background information for checking norms. The experiences of the participants in this study differed somewhat from those expressed by participants in surveys conducted by Egan & Sedersky (2003), where occupational therapists indicated that they were anxious and unsure about spirituality as there are multiple definitions and meanings of spirituality in practice. In this study, participants seemed to have found their own ways of working with spirituality through their clinical reasoning process. When there was uncertainty, it was probably due to the fact that they desired validity from clients' perspective and experienced tension between conflicting views rather than from anxiety and individual uncertainty (Egan & Sedersky, 2003).

4.7 Rethinking occupational therapy in context

Participants in the study indicated that client centeredness was significant to the extent that it preceded other considerations in this study. It also played an anchoring function in balancing structuralism with pragmatism tendencies within the clinical reasoning process. In addition, participants explained how their contexts of practice offered them both opportunities and challenges. If client centeredness and context were as important as would be suggested from a pragmatist viewpoint, it can be imagined that occupational therapy services needed to be reconsidered critically in order for relevant and beneficial work to occur in the diverse places that occupational therapists operate in worldwide. The current study was conducted in South Africa, which can be regarded as a member of the 'South' when one considers its position within the academic literature of occupational therapy. The knowledge generation within the profession has traditionally happened more in the North (represented by Europe and America) and

distributed to the rest of the world via the medium of English. The power dynamics of this arrangement have been discussed by several authors within occupational therapy e.g. Pollard et al (2009) and Iwama (2006). These authors advocate for more context relevant models in occupational therapy. Expanding on their ideas, the researcher suggests that sharing of knowledge from other parts of the world will increase diversity of occupational therapy models of practice. Subsequently, as therapists worldwide learn from one another, this will potentially strengthen the profession globally. There is no denying that the existing models are useful to occupational therapists worldwide. Models such as the Person Environment Occupation model (Law, et al, 1996) and the Model of Human Occupation (Kielhofner, 2008) have been used by therapists globally. However, these models come from an epistemological perspective in which humans are assumed to be individuals (Iwama, 2006). Hence, they cannot account fully for experiences in parts of the world where humans are viewed as interdependent and interconnected with each other and with their environment. Bearing in mind the above, cultural context is important if occupational therapists value providing services that are client centred and relevant (Iwama, 2006). The rationale for diverse and culturally relevant occupational therapy is clear in discussed in examples within this study.

Further, as participants suggested, it is important to consider the appropriateness of their clients' spiritual occupational engagements in order to discern whether their behaviours were health seeking or signs of illness. At this point one needs to critically ask 'appropriate to whom and according to what'? When one begins to ask such questions, influences like culture come into play. In other words, when occupational therapists in mental health services think about reintegration of their clients into their communities where interdependence is valued, they need to consider who the client(s) really are. Is it the individual whom the therapist interacts with in the workplace or does part of the client's environment (e.g. family and community) also become the client? There could be many implications in how occupational therapists 'do' client centred occupational therapy if the definition of 'client' was different to the traditional understanding, regardless of whether one takes a pragmatist or structuralist view of human existence, as they both stem from an individualistic viewpoint of people.

Summary

In this section, the process, experience and resources used to guide the clinical reasoning process were made sense of with the assistance of existing relevant literature. The clinical reasoning geared towards determining whether occupations of a spiritual nature were promoting health or illnesses was

highlighted as a complex and multi-layered 'weighing up' process. Such a process involved weighing up factors related to structuralist and pragmatist views which were anchored in the profession's fundamental philosophy of client centeredness. Traces of all the different tracks and styles of clinical reasoning could be found in the processes used by participants. These were however used in a manner that was influenced by the context in which participants worked. It was evident that both culture and politics influenced how participants reasoned clinically. Subsequently, culture and politics impacted on the content of occupational therapy participants provided for their clients.

University of Cape Town

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The present study aimed to describe clinical reasoning processes that occupational therapists underwent as they made decisions about occupations of a spiritual nature within mental health practice. An attempt was made to understand this topic by asking participants to describe their views about spirituality and their experiences regarding such decision-making. Overall, participants believed that spirituality has a place within occupational therapy. Spirituality was described by participants as one's connection to oneself within or to external sources i.e. a higher being, nature and other people that motivated individuals to live particular lifestyles according to associated values or engage with particular occupations. Although participants expressed that religion and spirituality were not equivalent, they described religion as the perspective from which their clients often spoke about and experienced spirituality. Clients' spiritual occupations described by participants included both active and passive occupations that were engaged individually or with others. These occupations included meaningful paid or voluntary work, socialising with others, spending quality time on their own, being in nature, gardening, walking, yoga, self care that expressed one's spirituality, seeking spiritual guidance and religious activities such as praying, reading religious motivational materials, smoking marijuana for Rastafarians and guided self reflection in therapeutic groups etc. The participants' views about the nature of the spiritual occupations for their clients were diverse. Amongst the diverse views, there were two opposing opinions about spiritual occupations. On the one hand, spiritual occupations were viewed as essentially positive and health seeking behaviours. On the other hand, the occupations themselves were perceived to be neutral and it was the health status of the individual that was seen to determine whether these occupations would have a positive or negative impact. An interesting third view surfaced during the study, where participants described a fine line between health giving spiritual occupations and illness originated ones. The line may be so fine that a particular spiritual occupation could be both health-giving and originated from illness, simultaneously. This alternative view is potentially helpful in enabling a way forward beyond dualistic categorisations of clients' spiritual occupations as either positive or negative.

The findings of this study demonstrated that clinical reasoning was a complex and non-linear course of action that occurred on several levels. Multiple sources of information about and from the clients were considered in the process. A key question that emerged was about the implication and meaning of the spiritual occupations to the clients in different contexts. This question symbolises the ongoing conversation between structuralism and pragmatism within occupational therapy. It reflects a weighing up process employing both inductive and deductive thinking as different modes or styles of clinical reasoning merged into a seamless synthesis of making sense of information and trusting one's intuition as a therapist, moderated by the client's input.

Client centeredness emerged as an anchoring principle in the clinical reasoning process in this study. It allowed participants to bring some equilibrium between structuralist and pragmatist elements of occupational therapy practice as they considered their clients' needs. The anchoring role of client centeredness became even more evident in the context of multidisciplinary teams where different opinions about the clients' spiritual occupational engagements were formed based on different views on human experiences. This is the context in which it becomes complex as organisational culture may place varying values onto the different views about the occupations of a spiritual nature that the clients engaged in. The result is that the situation reflects small 'p' politics in a manner described by Pollard et al (2009). Subsequently, the participants must not only do what may be best, but what is possible while navigating the culture and politics of their workplaces and the clients' background. In some instances, participants engaged in 'underground practices' as they navigated through such workplace politics and culture. Hence, 'underground practice' has emerged from this study in addition to Pollard et al's (2009) political tools (i.e. 'conflicts' and 'cooperation'), creating a continuum consisting of a trio of political strategies for occupational therapists.

Besides exploring the process of clinical reasoning, the present study was also interested in the resources participants may have used or found helpful during their discernments. Multiple sources of people were identified to be important resources by the participants. In the present study, people resources went beyond colleagues in the same workplace. Rather, it included the therapists' lived experiences, attitudes and worldviews, their clients in a moderation role, families, significant others, organisations and colleagues within the team for collateral and norm confirmation. Activity facilitators

and work supervisors were experienced as particularly resourceful, tying in with their role in enabling clients to experience spirituality in their occupational engagements as well. Instead of accessing individual people as resources, participants used a combination of people as a web of resources for various purposes towards a conclusion about their clients. Perhaps the interconnectedness in a collective culture such as the Ubuntu philosophy in South African can be attributed to as the reason why multiple people were seen as a web of resource for the participants.

5.2 Limitation to the study

At a micro level of the research process, the use of only occupational therapists from the state mental health services in the Western Cape Province as the sample may be a limitation to the study. Perspectives of other therapists from workplaces outside of this setting were not included. Additionally, the clients' perspectives on spiritual occupations were also unexplored. More understanding about spiritual occupations could be gained from both groups of individuals mentioned above as they may hold viewpoints that differ from those of the participants. Additionally, as the study was done as a mini dissertation, there was a limitation of how much time could be spent collecting, analysing and interpreting data.

Taking a step back and moving deeper to explore the research methodology, by using an explanatory protocol as suggested by Arocha & Patel (2008) in this study, participants were asked to recall and give an account of these prior experiences. Because the experiences were often not recent, it is possible that some detail may have been lost due to the limitation of distant memory. Secondly, Harries & Harries (2001) suggest that experienced therapists like the participants in this study may have difficulty articulating their clinical reasoning process as it has become subconscious and automatic. This could have had further impact on the details of the cases described. It would therefore have been interesting to have had a sample of more recently qualified occupational therapists in conjunction with the current participants for comparison.

In hindsight and through reflection, the research question in itself may have been a limitation. Although the dualistic concept of 'health seeking behaviours' or 'manifestation of psychiatric illnesses' was a helpful boundary to give this study in the beginning. The dualism posed by the research question in this particular way may have inhibited other alternative views of spiritual occupations.

5.3 Recommendations

5.3.1 Recommendation for future research

It could be of value to extend similar research to mental health services outside of the state institutions (e.g. private practice or non-governmental organisations), or to other practice areas for occupational therapy other than mental health services. In this way, similarity or diversity in how the clinical reasoning process may occur could be found. More clarity on the topic may be possible when there is a growing body of research on this topic. In order to allow for more robust theorizing related to this topic, grounded theory methodology may be useful in future studies.

Similarly, it could also be of value to conduct research aimed at comparing what mental health users (the clients themselves) consider as occupations of a spiritual nature to those identified by participants in this study. In addition, another study that asks more recently qualified occupational therapists about their clinical reasoning with regards to their clients' spiritual occupations may also bring forth new insight for further comparisons. The researcher would recommend that the spiritual occupations identified by participants within this study can be used as simulated cases to assess less experienced occupational therapists' clinical reasoning seeing that they may or may not have similar experiences to the study's participants due to their limited years of experience.

5.3.2 Recommendation for occupational therapy practice

In line with the literature reviewed, this study affirms the role of spirituality in occupational therapy. This is particularly so when spirituality is expressed through engagement in occupations of a spiritual nature. By responding to spiritual occupations that the clients find meaningful, occupational therapists are asserting client centeredness – a key philosophy within the profession. Occupational therapists should thus take a more active role in discovering practical ways of incorporating spirituality into practice through exploring occupations of a spiritual nature that facilitate health seeking behaviours with their clients. In looking at practical implications, occupational therapists will need to ask critical questions about how cultural and political factors will bear influence on what is valued as health giving and meaningful occupations of a spiritual nature. Thus, in agreement with Iwama (2006), occupational therapists can benefit from learning from more diverse models of occupational therapy globally. Occupational therapists from across the globe should share their thoughts and experiences on this topic to continue the debate and knowledge generation.

There are a number of recommendations emerging from this research that the researcher would like to make concerning helpful guidelines for the future process of discernment in dealing with occupations of a spiritual nature. In the light of the pressure and turnover in the mental health sector it is perhaps important to have tools that can aid occupational therapists in making clearer decisions. The researcher has placed these in a question format in order to move away from a reductionist certainty, towards a more inclusive practice.

1. Is the engagement appropriate and consistent with the client's own perspective with regards to their spiritual occupations across context and time?
2. How does the current engagement pattern compare to the norms and expectations of the client from the perspective of his or her pre-morbid behaviours and values, family, culture, or theoretical norms such as developmental stage?
3. What is the meaning experienced in this occupational engagement?
4. What are the implications to the client's health and to the workplace or the client's future environment in the community if the client continues with this spiritual occupational engagement?

Working with these questions would hopefully open some space for occupational therapists to find a diversity of voices on the subject of spirituality, which is generally lacking in the literature and practice. South Africa has a rich spiritual heritage, as can be seen from the sample of participants in the current study. By finding appropriate language for diverse contexts practices, occupational therapists may be empowered to respectfully challenge the dominance of the bio-medical model. In this way, it may allow for more transparency in clinical practice and offer occupational therapy students a language that can be used in a post-structural sense. Such transparency and clarity can hopefully bring about a new reality where a higher degree of holistic client centred occupational therapy is possible.

Reference List

Alers, V. & Crouch, R. (Eds.) (2010). *Occupational therapy: an African perspective*. Johannesburg, R.S.A.: Sarah Shorten Publishers.

American association of occupational therapy (1999 – 2010). *About occupational therapy: what is occupational therapy?* Accessed online via <http://www.aota.org/Consumers.aspx>, [2010-12-13].

Arocha J.F. & Patel V.L. (2008). Methods in the study of clinical reasoning. In Higgs, J., Jones, M.A., Loftus, S. & Christensen, N. (2008). Chapter 17, pg 193-204. *Clinical reasoning in the health professions, 3rd edition*. New York: Butterworth Heinemann, Churchill Livingstone, Elsevier.

Baetz, M., Griffin, R., Bowen, R. & Marcous, G. (2004). Spirituality and psychiatry in Canada: psychiatric practice compared with patient expectations. *Canadian Journal of Psychiatry*, Vol. 49, no. 4, pg 265-271.

Ballou Hamilton, T. (2008). Narrative reasoning. In Boyt Schell, B.A. & Schell, J.W. (2008). *Clinical and professional reasoning in occupational therapy*, Chapter 6, pg Pg 125 – 168. United States of America: Wolters Kluwer Health: Lippincott Williams & Wilkins.

Bannigan, K. & Moores, A. (2009). A model of professional thinking: integrating reflective practice and evidence based practice. *Canadian Journal of Occupational Therapy*, Vol. 76, No. 5, pg 342 – 350. Accessed via ProQuest Journals, [2010-09-28].

Banning, M. (2007). A review of clinical decision making: models and current research. *Journal of Clinical Nursing*, Feb 2007, 23 pages. Accessed via Google Scholar, [2010-08-22].

Boyt Schell, B.A. & Schell, J.W. (2008). *Clinical and professional reasoning in occupational therapy*. Wolters Kluwer Health: Lippincott Williams & Wilkins, United States of America.

British occupational therapy association (?). *About occupational therapy*. Accessed online via [http://www.cot.co.uk/Homepage/About Occupational Therapy/](http://www.cot.co.uk/Homepage/About_Occupational_Therapy/), [2010-12-13].

Broodryk, J. (2006). *Ubuntu: life-coping skills from Africa*. South Africa: Knores Publishing.

Cader, R., Campbell, S. & Watson, D. (2005). Cognitive continuum theory in nursing decision-making. *Journal of Advanced Nursing*, Vol. 49, no. 4, pg 397-405. Accessed via Google Scholar, [2010-08-22].

Canadian model of occupational therapy (1997) as cited in Baptiste, S. (2005). Spirituality in occupational therapy. In Meier, A., O'Connor, T.S.J. & VanKatWyk, P.L. (2005). *Spirituality & Health: multidisciplinary explorations*. Waterloo, Ont: Wilfrid Laurier University Press.

Cara, E. & MacRae, A. (2005). *Psychosocial occupational therapy: a clinical practice*, 2nd edition. Australia: Thomson Delmar Learning.

Case, A. Menendez, A. & Ardington, C. (2005). *Health seeking behaviour in Northern KwaZulu-Natal*. Centre for Social Science Research, University of Cape Town. CSSR Working Paper no. 116, May 2005.

Chaffey, L., Unsworth, C. & Fossey, E. (2010). A grounded theory of intuition among occupational therapists in mental health practice. *British Journal of Occupational Therapy*, Vol. 73, no. 7, July 2010, pg 300 -308. Accessed via Ebscohost, [2010-08-21].

Christiansen, C. & Baum, C. (1997). *Occupational therapy: enabling function and well-being*, 2nd edition. Thorofare, N.J.: SLACK Incorporated.

Collins, M. (2007). Spiritual emergency and occupational Identity: a transpersonal perspective. *British Journal of Occupational Therapy*, Vol. 70, No. 12, pg 504-512.

Collins pocket English dictionary (2010). Glasgow, UK: Harper Collins Publishers.

Cole, M.B. (2005). *Group dynamics in occupational therapy: the theoretical basis and practice application of group intervention*, 3rd edition. Thorofare, NJ: Slack.

Creswell, J.W. (2003). *Research design: qualitative, quantitative and mixed methods approach*, 2nd edition. United States of America: SAGE Publications.

Creswell, J.W. (1998) & (2007). *Qualitative Inquiry & Research Design: choosing among five approaches*, 1st & 2nd edition. United States of America: SAGE Publications, Inc..

Crouch, R. & Alers, V. (Eds) (2005). *Occupational therapy in psychiatry and mental health*, 4th edition. London and Philadelphia: Whurr Publishers.

Department of health (PAWC) (1999). Framework for mental health services in the Western Cape province. *Mental Health Programme, Directorate Programme Development*. 4 March, 1999.

De Witt, P. (2005). Creative ability: a model for psychosocial occupational therapy. In Crouch, R. & Alers, V. (Eds) (2005), chapter 1: pg 3 – 61. *Occupational therapy in psychiatry and mental health*, 4th edition. London and Philadelphia: Whurr Publishers.

Dictionary.com (2011). Discernment.

Accessed online at <http://dictionary.reference.com/browse/discernment>, [2011-01-29].

Eeles, J., Lowe T. & Wellman, N. (2003) Spirituality or psychosis? An exploration of the criteria that nurses use to evaluate spiritual-typed experiences reported by patients. *International Journal of Nursing Studies*, Volume 40, No. 2, Pg 197 – 206. Accessed via ScienceDirect, [2008-09-30].

Egan, M. & Swedersky, J. (2003). Spirituality as experienced by occupational therapists in practice. *American Journal of Occupational Therapy*, Vol. 57, no. 5, pg 525-533.

Emanuel E.J., Wendler, D., Killen, J. & Grady, C. (2004). What makes clinical research in developing countries ethical? The benchmarks of ethical research. *Journal of Infectious Diseases*, Vol. 189, perspective, pg 930-937. Accessed via Google Scholars, [2009-04-28]. Online at <http://www.journals.uchicago.edu/doi/pdf/10.1086/381709?cookieSet=1>.

Farah, J. & McColl, M.A. (2008). Exploring prayer as a spiritual modality. *Canadian Journal of Occupational Therapy*, Vol. 75, No. 1; p. 5-18. Accessed via ProQuest Journals, [2008-09-30].

Finlay, L. (2004). *The practice of psychosocial occupational therapy*, 3rd edition. United Kingdom: Nelson Thornes Ltd.

Fisher, J.W., Francis, L.J. & Johnson, P. (2000). Assessing spiritual health via four domains of spiritual wellbeing: the SH4DI. *Pastoral Psychology*, Vol. 49, No.2, pg 133-145.

Fontana, A. & Frey, J.H. in Denzin, N.K. & Lincoln, Y.S. (2008). *Collecting and interpreting qualitative materials*, 3rd Edition, pg 115-160. United States of America: Sage Publications.

Flannery Wainwright, S. & Quinn McGinnis, P. (2009). Factors that influence the clinical decision-making of rehabilitation professionals in long-term care settings. *Journal of Allied Health*, Vol. 38, no. 3, pg 143 – 151. Accessed via ProQuest Journals, [2010-08-22].

Friesen, N. (2008). Critical theory: ideology critique and the myths of E-learning. *Ubiquity*, Vol. 9, issue 22, pg 3-9. As cited at http://www.acm.org/ubiquity/volume_9/v9i22_friesen.html, [2008-09-04].

Gelfand, M., Mavi, S., Drummond, R.B. & Ndemera, B. (1985). *The traditional medical practitioner in Zimbabwe*. Gweru, Zimbabwe: Mambo Press.

Guba, .EG.& Lincoln, Y.S. (1994). *Competing paradigms in qualitative research*. In Denzin, N.K.&Lincoln, Y.S. (eds.) *Handbook of Qualitative Research*, pg. 105-117. London: SAGE.

Hammell, K.W. (2001). Intrinsicity: reconsidering spirituality, meaning(s) and mandates. *Canadian Journal of Occupational Therapy*, Vol. 68, no.3, pg 186-193. Accessed via ProQuest Journals, [2008-05-20].

Hammond, K.R. (1996). *Human judgement and social policy: irreducible uncertainty, inevitable error*. New York: Oxford University Press. In Cader, R., Campbell, S. & Watson, D. (2005). Cognitive continuum theory in nursing decision-making. *Journal of Advanced Nursing*, Vol. 49, no. 4, pg 397-405. Accessed via Google Scholar, [2010-08-22].

Hansen, E.C. (2006). Research design and rigour. *Successful qualitative health research: a practical introduction*. Chapter 3, pg 46-75. United States of America: Open University Press.

Harries, P.A. & Harries, C. (2001). Studying clinical reasoning, part 1: have we been taking the wrong 'track'? *British Journal of Occupational Therapy*, Vol. 64, no. 4, pg 164 – 168. Accessed via EscoHost, [2010-8-21].

Hawks, S. (1994). Spiritual health: definition and theory. *Wellness Perspectives*, Summer, 1994, Vol. 10, Issue 4, pg 3-14. Accessed via EBSCOHOST, [2008-09-25].

Higgs, J., Jones, M.A., Loftus, S. & Christensen, N. (2008). *Clinical reasoning in the health professions*, 3rd edition. New York, U.S.A.: Butterworth Heinemann, Churchill Livingstone Elsevier.

Hooper, B. & Wood, W. (2002). Pragmatism and structuralism in occupational therapy: the long conversation. *American Journal of Occupational Therapy*, Vol. 56, no. 1, pg 40 -50.

Ikiugu, M. N. (2007). *Psychosocial conceptual practice models in occupational therapy: building adaptive capability*. United States: Mosby Elsevier.

Iwama, M.K. (2006). *The Kawa Model: culturally relevant occupational therapy*. Edinburgh, New York: Elsevier Churchill Livingstone.

Janesick V.J. (2004). *"Stretching" exercises for qualitative researchers*, 2nd edition. United States of America: SAGE Publications.

Jennings, P. (1997). What is happening in RE? A study of teachers' responses to government communications. Paper presented in June at the Fourth Annual Conference on "Education, Spirituality and the Whole Child," *Roehampton Institute*, London. As cited in Fisher, J.W., Francis, L.J. & Johnson, P. (2000). Assessing spiritual health via four domains of spiritual wellbeing: the SH4DI. *Pastoral Psychology*, Vol. 49, No.2, pg 133-145.

Johnston, D. & Mayers, C. (2005). Spirituality: a review of how occupational therapists acknowledge, assess and meet spiritual needs. *British Journal of Occupational Therapy*, Vol. 68, no. 9, pg 386-392.

Kang, C. (2003). A psychospiritual integration frame of reference for occupational therapy. Part 1: conceptual foundation. *Australian Occupational Therapy Journal*, Vol. 50, pg 92-103. Accessed via Google Scholars, [2010-12-27].

Kanny, E.M. & Yarett Slater, D. (2008). Ethical reasoning. In Boyt Schell, B.A. & Schell, J.W. (2008). *Clinical and professional reasoning in occupational therapy*, Chapter 8, pg 188 – 208. United States of America: Wolters Kluwer Health: Lippincott Williams & Wilkins.

Kielhofner, G. (2008). *Model of human occupation: theory and application*, 4th edition. Baltimore, M.D.: Lippincott Williams & Wilkins.

Kinsella, E.A., Park, A.J.S., Appiagyei, J., Chang, E., Chow, D. (2008). Through the eyes of students: ethical tensions in occupational therapy. *Canadian Journal of Occupational Therapy*, Vol. 75, no. 3, pg 176 – 183. Accessed via ProQuest Journals, [2010-09-28].

Koss-Chioino, J.D.K. & Hefner, P. (2006). *Spiritual Transformation and Healing: anthropological, theological, neuroscientific, and clinical perspectives*. Lanham, MD: Altamira Press, Rowman & Littlefield publishers, Inc.

Koss-Chioino, J.D.K. (2006). Spiritual transformation and radical empathy in ritual healing and therapeutic relationships. In Koss-Chioino, J.D.K. & Hefner, P. (2006). *Spiritual Transformation and Healing: anthropological, theological, neuroscientific, and clinical perspectives*, Chapter 4, pp 45-61. Lanham, MD: Altamira Press, Rowman & Littlefield publishers, Inc.

Kristeller, J.L. & Hummel, L.M. (2006). Spiritual engagement and transformation in cancer patients: the experience, of the patient, the role of the physician. In Koss-Chioino, J.D.K. & Hefner, P. (2006). *Spiritual Transformation and Healing: anthropological, theological, neuroscientific, and clinical perspectives*, Chapter 16, pp 263-280. Lanham, MD: Altamira Press, Rowman & Littlefield publishers, Inc.

Lake, J.H. & Spiegel, D. (Eds) (2007). *Complementary and alternative treatments in mental health care*. Washington, D.C.: American Psychiatric Publishing, Inc.

Matsumoto, D. (1994) as cited in Laliberte Rudman, D. & Dennhardt, S. (2008). Shaping knowledge regarding occupation: examining the cultural underpinnings of the evolving concept of occupational

- identity. *Australian Occupational Therapy Journal*, Vol. 55, pg 153 – 162, available on <http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1630.2007.00715.x/pdf>, [2011-04-28].
- Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P. & Letts, L. (1996). *Canadian Journal of Occupational Therapy*, vol. 63, no.1, pg 9-23. Accessed via Google Scholar, [2010-12-11].
- Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.
- Long T. & Johnson M. (2000). Rigour, reliability and validity in qualitative research. *Clinical Effectiveness in Nursing*, Vol. 4, pg 30-37. Harcourt Publishers Ltd. Accessed via ScienceDirect, [2008-09-30].
- Lund, C., Kleintjies, S., Kakuma, R. & Flisher, A.J. (2010). Public sector mental health systems in South Africa: inter-provincial comparisons and policy implications. *Soc Psychiat Epidemiol*, Vol. 45, pg 393-404. Accessed via Springerlink, [2010-07-21].
- Mattingly, C. & Fleming M.H. (1994). *Clinical reasoning: forms of inquiry in a therapeutic practice*. Philadelphia: F.A. Davis Company.
- Mays, N. & Pope, C. (2000). Qualitative research in health care: assessing quality in qualitative research. *British Medical Journal*, Vol. 320, 1 January, 2000, pg 50-52. Accessed via Pubmed Central, [2008-09-05].
- McColl, M.A. (2000). Muriel Driver Memorial Lecture: spirit, occupation and disability. *Canadian Journal of Occupational Therapy*, Vol. 67, No. 4, pg 217-228. Accessed via ProQuest Journals, [2008-06-05].
- McGrath, P., & Newell, C. (2004). The human connection: a case study of spirituality and disability. *Journal of Religion, Disability & Health*, Vol. 8, No. 1, pg 89-104. Accessed via EBSCO Host, [2008-08-26].
- Meyer, C. (2000). Providing spiritual care: mutual journey of discovery. *The Kansas Nurse*, Vol. 75, Issue 10. Pg 1-3. Accessed via EBSCO Host, [2008-07-25].
- Niehaus, D.J.H., Koen, L., Galal, U., Dhansay, K., Oosthuizen, P.P., Emsley, R.A. & Jordaan, E. (2008). Crisis discharges and readmission risk in acute psychiatric male inpatients. *BMC Psychiatry*, Vol. 8, no. 44, pg 1-6. Available online at www.biomedcentral.com/content/pdf/1471-244X-8-44.pdf, [2010-07-21].
- Occupational therapy association South Africa (2010). *Definition of occupational therapy*. Accessed online via <http://www.otasa.org.za/about/index.html>, [2010-12-13].
- Occupational therapy Australia (?). *What is occupational therapy?* Accessed online via <http://www.ausot.com.au/inner.asp?pageid=4#what is it>, [2010-12-13].
- Okasha, A. (2002). Mental health in Africa: the role of the WPA. *World Psychiatry*, Vol. 1, no. 1, pg 32-35. In Alers, V. & Crouch, R. (Eds.) (2010). *Occupational therapy: an African perspective*. Johannesburg, R.S.A.: Sarah Shorten Publishers.
- Philpot, M. (2004). An introduction to ethics of research in psychiatry. *Psychiatry*, Vol. 3, no. 3, pp 26-29. The Medicine Publishing Company Ltd. Accessed via Science Direct, [2008-04-20]
- Pitts, D.B. (2005). Evaluation and assessment. In Cara, E. & MacRae, A. (2005). *Psychosocial occupational therapy: a clinical practice*, 2nd edition. Chapter 17, pg 477-507.

Pitts, M. & Smith, A. (2007). *Researching the margins: strategies for ethical and rigorous research with marginalised communities*. Basingstoke [England], New York: Palgrave Macmillan.

Pollard, N., Sakellarios, D. & Kronenberg, F. (eds) (2009). *A political practice of occupational therapy*. Europe: Churchill Livingstone, Elsevier.

Researcher Journal (2010). Cape Town, South Africa.

Richards, T. (2008). *NVivo: qualitative analysis program*. Information available from <http://www.qsrinternational.com/>, [2008-08-26].

Roberts, L.W. & Roberts, B. (1999). Psychiatric research ethics: an overview of evolving guidelines and current ethical dilemmas in the study of mental illness. *Biological Psychiatry*, Vol.46, pg 1025-1038.

Robinson, A. (1994). Spirituality and risk: Toward an understanding. *Holistic Nursing Practice*, Vol. 8, No. 2, pg 1–7. As cited in Fisher, J.W., Francis, L.J. & Johnson, P. (2000). Assessing spiritual health via four domains of spiritual wellbeing: the SH4DI. *Pastoral Psychology*, Vol. 49, No.2, pg 133-145.

Schulz, E. (2008). OT-QUEST assessment. In Hemphill-Person, B.J. (2008). *Assessments in occupational therapy mental health: an integrative approach*, Chapter 17, pg 263-292, 2nd edition. Thorefare, N.J.: SLACK Incorporated.

Sims, A. (2003). *Mysterious ways: spirituality and British psychiatry in the 20th century*. Available on www.rcpsycho.ac.uk. Accessed via EBSCOHost, [2008-05-19].

Stake, R.E. (2006). *The multiple case study analysis*. New York: The Guilford Press.

Stake, R.E. (1995). *The art of case study research*. United States of America: SAGE Publications.

Swartz, L. (1998). *Culture and mental health: a southern African view*. Cape Town: Oxford University Press.

Townsend, E.A. & Polatajko, H. J. (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation*. Ottawa. In Canadian association of occupational therapy (?). Occupational therapy – definition. Accessed online via <http://www.caot.ca/default.asp?pageid=1344>, [2010-12-13].

Unruh, A.M., Versnel, J. & Kerr, N. (2002). Spirituality unplugged: a review of commonalities and contentions, and a resolution. *Canadian Journal of Occupational Therapy*, Vol. 69, No. 1, pg 5-19. Accessed via ProQuest Journals, [2008-09-30].

Unsworth, C.A. (2004). Clinical reasoning: how do pragmatic reasoning, worldview and client-centeredness fit? *British Journal of Occupational Therapy*, Vol. 67, no. 1, pg 10 – 19. Accessed via EscoHost, [2010-8-21].

Ward, J.D. (2003). The nature of clinical reasoning with groups: a phenomenological study of an occupational therapist in community mental health. *American Journal of Occupational Therapy*, vol. 57, no. 6, Nov/Dec 2003, pg 625 – 634. Accessed via Ebscohost, [2010-8-21].

Wilcock, A.A. (2006). *An occupational perspective of health*, 2nd edition. Thorofare, NJ: Slack.

Wikipedia.org (2011). Discernment. Accessed online at <http://en.wikipedia.org/wiki/Discernment>, [2011-01-29].

Wilding, C. (2002). Where angels fear to tread: is spirituality relevant to occupational therapy practice? *Australian Occupational Therapy Journal*, Vol. 49, pg 44-47.

Wilding, C., May, E. & Muir-Cochrane, E. (2005). Experience of spirituality, mental illness and occupation: a life-sustaining phenomenon. *Australian Occupational Therapy Journal*, Vol. 52, pg 2-9.

World federation of occupational therapy (2004). *What is occupational therapy?* Accessed online via <http://www.wfot.org/information.asp>, [2010-12-13].

University of Cape Town

Appendices

Appendix 1 (a): Ethics approval documents from University of Cape Town



UNIVERSITY OF CAPE TOWN

Health Sciences Faculty
Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
e-mail: nosi.tywabi@uct.ac.za

21 July 2009

REC REF: 292/2009

Mrs KY Hess
Occupational Therapy
Health & Rehab Sciences

Dear Mrs Hess

PROJECT TITLE: A STUDY ON THE DISCERNMENT BY OCCUPATIONAL THERAPISTS ON WHETHER MENTAL HEALTH SERVICE USERS' OCCUPATIONS OF A SPIRITUAL NATURE ARE HEALTH SEEKING BEHAVIOURS OR MANIFESTATIONS OF ILLNESS

Thank you for submitting your study to the Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above mentioned study.

Approval is granted for one year until 30 July 2010.

Please submit an annual progress report if the study extends beyond the approval period. Alternatively, please submit a brief summary of your findings so that we can close our records.

Several methodological recommendations were identified which you may want to consider:

- Questions used in the interview could be developed further. The main aim is to explore the clinical reasoning process participants used to arrive at their decision. This is not actually asked in the interview. Similarly, there are no questions related to objective 2 which deal with the resources that participants used. Question 3 is also unclear and 'How did you find' is not a very specific question: does it mean how the respondent "felt" about the experience, how they identified information sources or in what way did they interpret the experience?

Please quote the REC REF in all your correspondence.

lemjedi

Yours sincerely

PROFESSOR M/BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

Appendix 1 (b): Ethics approval documents from Stellenbosch University



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

27 October 2009

MAILED

Ms A Ka Yan Hess
A305 Devonshire Hill
13 Grotto Road
Rondebosch
Cape Town
7700

Dear Ms Ka Yan Hess

"A study on the discernment by occupational therapists on whether mental health service users' occupations of a spiritual nature are health seeking behaviours or manifestations of illness."

ETHICS REFERENCE NO: N09/10/278

RE : DIRECT APPROVAL

It is a pleasure to inform you that a review panel of the Health Research Ethics Committee has approved the above-mentioned project on 26 October 2009, including the ethical aspects involved, for a period of one year from this date.

This project is therefore now registered and you can proceed with the work. Please quote the above-mentioned project number in ALL future correspondence. You may start with the project, but this approval will however be submitted at the next meeting of the Health Research Ethics Committee for ratification. Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary to make their final decision.

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.

Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Approval Date: 26 October 2009

Expiry Date: 26 October 2010

27 October 2009 09:33

Page 1 of 2



Fakulteit Gesondheidswetenskappe • Faculty of Health Sciences



Verbind tot Optimale Gesondheid • Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun • Division of Research Development and Support
Postbus/PO Box 19063 • Tygerberg 7505 • Suid-Afrika/South Africa
Tel.: +27 21 938 9075 • Faks/Fax: +27 21 931 3352

Feb. 11 2011 10:18PM PT

PHONE NO. :

FROM : THE HO FAMILY



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvennoot • your knowledge partner

Yours faithfully

MRS MERTRUDE DAVIDS

RESEARCH DEVELOPMENT AND SUPPORT

Tel: 021 938 9207 / E-mail: mertrude@sun.ac.za

Fax: 021 931 3352

27 October 2009 09:33

Page 2 of 2



Fakulteit Gesondheidswetenskappe • Faculty of Health Sciences



Verbind tot Optimale Gesondheid • Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun • Division of Research Development and Support

Pasbus/PO Box : 9063 • Tygerberg 7505 • Suid-Afrika/South Africa
Tel.: +27 21 938 9075 • Faks/Fax: +27 21 931 3352

Feb. 11 2011 10:17AM PT

PHONE NO. :

FROM : THE HO FAMILY

Appendix 1 (c): Ethics approval from department of health, Western Cape

07/12/2009 15:45

0214939195

FINANCE

PAGE 01/01



Verwysing
Reference
Isa:ethiso 197516-047009

Navres
Enquiries
Indu:25 Dr N Res:

Ts
Telephone 021 493 9393
ifowun:

Departement van Gesondheid
Department of Health
iSaba Iezempilo

Ms Ka Yan Hess
A305 Devonshire Hill
13 grotto Road
Rondebosch
7700

Fax number: 021 5541717

Dear Ms Hess

RE: To describe the clinical reasoning process occupational therapists in mental health undergo when determining whether occupations of a spiritual nature are health seeking behaviours or manifestations of a psychiatric illness.

Thank you for submitting your proposal to undertake the above mentioned study. Your study has been approved.

Please contact the following people:
Valkenberg Hospital: Dr B Schmidt Bschmidt@qgwc.gov.za
Lentegeur Hospital: Ms L Toorn Ltoorn@qgwc.gov.za
Alexander Hospital: Ms W Sonnie Wassonnie@qgwc.gov.za
Stikland Hospital: Mr M Visser Mvisser@qgwc.gov.za

Yours Sincerely

DR J OUPHOF
DEPUTY-DIRECTOR GENERAL
DISTRICT HEALTH SERVICES AND PROGRAMME

DATE: 07/12/2009

CC: DR L HERRING
DR B SCHMIDT
DR G MARINIS
MR C BARNARD
MR M VISSEK

DIRECTOR: ASSOCIATED PSYCHIATRIC HOSPITALS
CEO VALKENBERG HOSPITAL
CEO LENTEGEUR HOSPITAL
CEO ALEXANDER HOSPITAL
CEO STIKLAND HOSPITAL

Postbus 4
Rondebosch 7700
KAPSTAD
7700

4 Corp Street
PO Box 2900
CAPE TOWN
8000

Feb. 11 2011 10:16AM PT

PHONE NO. :

FROM : THE HO FAMILY

Appendix 2: Power point presentation for participant recruitment

A study on the discernment by occupational therapists on whether mental health service users' occupations of a spiritual nature are health seeking behaviours or manifestations of illness.

KAYAN HESS (ANITA)
Valkenberg Hospital – Male Admissions
University of Cape Town - MSc (OCC THERAPY)

Important terms

- Discernment = decision making / clinical reasoning.
- Spiritual natured occupations = activity of daily living that seeks to express what an individual finds connection(s) with, of which gives him/her a sense of purpose & meaning in life
- Spirituality = "experiencing a meaningful connection to our core selves, other beings, the world, and/or a greater power, as expressed through our reflections, narratives, and actions, within the context of space and time". (Schulz, 2008: pg 264)

Introduction

- Rationale
- Research Question, Aim & Objectives
- Literature Review
 - Spirituality as health seeking behaviour
 - Spirituality as symptomology in mental health
 - Spirituality & OT
 - Clinical reasoning in OT
- Methodology
 - Research Method
 - Sample Selection
 - Data collection and analysis
 - Rigor & Trustworthiness
 - Ethical considerations

RATIONALE

Rationale: Why Spirituality in OT?

- OTs value and are concerned with spirituality as it can contribute towards health & well being
- YET, limited research is available on the "how to" practically, esp. none from RSA

YET...

Therapists who are sensitive to diverse spiritual expressions through occupations can be of better service to our clients

Rationale: Why Spirituality in Mental Health?

- Spirituality – It's not always straight forward, psychiatric symptoms vs. healthy behaviour?
- In Mental Health, spirituality has the potential for
 - † Motivation & Resiliency
 - † Hope, personal empowerment
 - † Suicide, delinquency, criminal behaviour & substance use

(Chenier, 2007)

Why South Africa?
Diversity!! We got much to offer...

QUESTION, AIM & OBJECTIVES

Research question

- **What is** the clinical reasoning process followed by occupational therapists in mental health to discern whether occupations of a spiritual nature are health seeking behaviours or manifestations of a psychiatric illness in Western Cape, South Africa?

Research aim

- To **describe** the clinical reasoning process occupational therapists in mental health undergo when determining whether occupations of a spiritual nature are health seeking behaviours or manifestations of a psychiatric illness

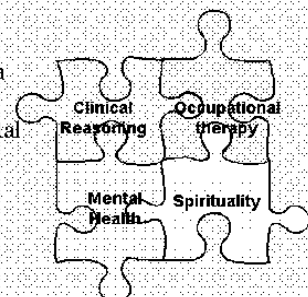
Research objectives

- To **identify the key elements within the clinical reasoning** process participants employ when they determine whether occupations of a spiritual nature are health seeking behaviours or manifestations of a psychiatric illness.
- To **identify resources** from which participants draw in order to inform their clinical reasoning process
- To **describe the experience** of participants in making the decision whether their clients' engagements in occupations of a spiritual nature are health seeking or a manifestation of psychiatric illnesses.

LITERATURE REVIEW

The combination

- Not explored yet.
- Not from South Africa
- Not from OTs in mental health



Spirituality as health seeking behaviours

- | | |
|--|---|
| a) Personalists: e.g. meditation | a) Has much to do with culture |
| b) Contraculturalists: e.g. act of services & volunteerism | e.g. yoga, qigong, religious beliefs, meditations and exercises |
| c) Remonstrant-ritualists: e.g. Faith, list | 6 SOUTH AFRICA |
| d) Believers: e.g. Church goers | Seeking traditional healers' help |
| e) Essentialists: (those who are concerned with connecting with self others & environments BUT NOT higher being) | |
| f) Globalist: all the above | |

Key: spiritual well being means positive connections with others, expression of self & experience of transcendence through actions & choices

Spirituality as symptomology

• In Mental Health

- Behaviours such as over-concerns with religion, hearing voices or seeing things are equated as 'symptoms' within an 'illness'

• However... Consider the follow examples...

- × The process of becoming a traditional healer?
- × Rastafarian & substance use in their religious belief?

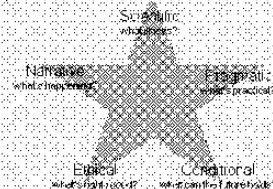
Spirituality & OT

- Defining, describing or reflecting on spirituality "essence of the self", "source of will and intention", "source of meaning"
- Potential modality e.g. prayer
- Experiences of therapists & clients
- Assessment (Schulz, 2008)

*** Closest study → nurses in psychiatry
Used evaluation criteria based on outcome, nature, context and explanatory modes

Clinical Reasoning in OT

- Clinical reasoning – "deliberations of acting to achieve the "best good" in a particular context for that client at that time" - Mattingly & Fleming (1994: pg 10-11)



METHODOLOGY

Methodology

• Multiple case study

- "the study of an issue explored through one or more cases within a bounded system" (Creswell, 2007: pg.73).
- The system for the study – bounded by location (Cape Town), context (spirituality in mental health) & persons (OTs & their clients).

Sampling

- Four cases through purposive sampling
 - Because so researcher can select cases that she can learn from maximally
 - Purposively selected along the description of
 - ✦ OTs working in mental health for at least 2 years.
 - ✦ OTs who had dealt with spiritual natured occupations in 2-3 diff. occasions/cases.
 - ✦ To ensure diversity, also looking for difference in: age, religious beliefs, culture/ethnic group.

Data collection

- Voice recorded interviews using a semi-structured interview protocol
 - Questions around
 - ✦ 1) What situations had you faced where you had to decide?
 - ✦ 2) Did you arrive at a workable solution? How?
 - ✦ 3) Who or what resources assisted you in the process?
 - ✦ 4) What was your experience in the situation?

Data analysis

Revising and refining	First I thought that I make some rules, I made a list of codes. Junnick (2004) suggests that attention to be paid to where the information appears in the data.
Describing	Describe case and its context
Classifying	Use categorical aggregation to establish themes or patterns.
Interpreting	Use direct interpretation Develop narrative generalization Attention will also be paid to the dominating ideology, or that culture is essential before the next step can be taken with it. (Patton, 2000) Specifically, the researcher will look closely at information that may be at odds with the interpretive and explanatory knowledge (Kiss)
Representing and visualizing	Present in depth portion of case using narrative, table and figures, which is also supported by Junnick (2004)

*New software will be used in the data analysis process

Rigor (1)

Credibility (integrity of the study)	Peer review by non-participating OTs at designing, data analysis & reporting stage. Methodological transparency by clear description of research methodology in contextualised data.
Dependability (suitability of methods, transparency of methods & analysis)	Systematic choice of methodology for dependability in design stage. Implementation as per timeline & document adaptations and its rationale for research process dependability. Data collection, & analysis reliability Free-text interview protocol Transcription per verification Check sample data & its analysis with peers

Rigor (2)

Confirmability (avoid distortion of reality from the context in which the data emerged)	Data triangulation through: member checking, comparing inter-case data with supporting documents and researcher's observation. Reflexive research journal to continue make researcher aware of own positioning to achieve relative neutrality when dealing with data. Use contextualised data to support interrelationships. Use visual representation for explanation
Transferability (applicability of findings to other settings)	Report in detail about context, methods, sampling and findings → so readers can decide if data is applicable to their settings.

Ethical considerations

Non-maleficence (tend to cause no harm or distress) Case of disclosure of participation (transparency)	Respect autonomy process with autonomy of participants in informed consent	Confidentiality search for data, pseudonymisation, anonymisation & removal of association to workplaces
Beneficence contribution to the knowledge of the profession in informed consent	Justice member checking, fair selection, on the decided criteria	

Appendix 3: Information document and informed consent forms

Information on the study:

The study title: “A study on the discernment by occupational therapists on whether mental health service users’ occupations of a spiritual nature are health seeking behaviours or manifestations of illness”. (UCT Research Ethics Approval No.: 292/2009), can be contacted at E52- 23 Old Main Building, Groote Schuur Hospital, Observatory, 7925 or Tel: 27 21 4066492)

Dear Occupational Therapist

Thank you for taking the time to read about my research. My name is Ka Yan Hess (also known as Anita). I am currently a Masters student in Occupational Therapy at the University of Cape Town. As part of fulfilling the requirements of my MSc (OT) study, I have decided to study how occupational therapists clinically reason whether a spiritual natured occupation is a health-seeking behaviour or a manifestation of mental illnesses in the Western Cape, South Africa.

Why conduct the proposed study?

There is limited research on how occupational therapists discern whether occupations of a spiritual nature are health seeking behaviours or a manifestation of psychiatric illnesses, especially in South Africa. The study aims to describe the clinical reasoning process occupational therapists follow when discerning the above. Mental health was chosen to be the focus as spirituality expressed in health seeking behaviours or illnesses are particularly interesting. Potential knowledge on the clinical reasoning process, regarding the above, from this study can assist therapists in their interventions with clients. As a result, the knowledge gained can contribute towards more sensitive, holistic and client centred occupational therapy interventions for mental health service users in South Africa.

If you think you have dealt with discerning whether your clients’ engagements in spiritual natured occupations were health seeking behaviours or manifestation of their illnesses in three different occasions in your practise and you have worked in mental health for at least two years, you are who I am interested in. Four therapists meeting the above criteria are required as cases for this study. The four most diverse willing therapists meeting the criteria will be picked from those who indicate their willingness to participate according to age, culture and religious beliefs. The four participants will be contacted by the researcher personally through telephone and email by December 2009 to set up interviews for data collection in 2010.

The involvement should you become a participant:

- A vocally recorded 45-60 minutes interview with the researcher at a time and place that is convenient and comfortable for you where we talk about your clinical experiences dealing with spirituality and how did you decide and reason whether occupations of a spiritual nature were health-seeking or a manifestation of your clients’ psychiatric illness.

- Possibility of receiving no more than three follow up calls/emails from the researcher to clarify what was discussed in the interview. Should it be of benefit and only with your permission; follow up interviews may be set up.
- A follow up session of 30-45 minutes where we meet to discuss the findings of the research after data analysis is done. This process will allow you to see the findings and where you may have been quoted and to confirm whether or not you feel comfortable being quoted.

What about risks and benefits or withdrawing from the study?

Although there is no direct personal benefit for participating in this study, international and local therapists may benefit by learning from your experiences in how to discern whether occupations of spiritual nature are health seeking behaviours or manifestation of illness. Secondly, there is minimal risk associated with being in interviews. No physical harm is associated with interviews, should participants experience any form of psychological distress, the researcher will discontinue the interview. Together with the participant(s), the possibility and necessity of counselling resources will be considered should this occur.

The researcher respect your privacy and would like to assured you that the identity of participants and their workplaces will be protected through pseudonym and disassociation of identifiable contextual information from presented data. Further, data will be secured in locked cupboards and password protected electronically so that I as the researcher will be the only one that has access to your confidential information.

Participation in this study is voluntary and therefore you have the right to withdraw from the study any time should you wish to do so. The researcher will fully respect your choice and no questions will be asked.

Should you have any questions, please feel free to contact me by calling 084 335 6782 / 021 4403202 (W) or emailing me at <mailto:kayan.anita@gmail.com> or my supervisor Elelwani Ramugando at elelwani.ramugando@uct.ac.za or (021) 406-6401.

Thank you for your time!

Yours faithfully,

Ka Yan Hess (Anita)
University of Cape Town MSc (OT) Student Researcher (HXXKAX001)
Valkenberg Hospital: Male Admissions Occupational Therapist

Informed Consent Form

Please indicate below with a tick in the appropriate box whether or not you would be willing to take part in the study "A study on the discernment by occupational therapists on whether mental health service users' occupations of a spiritual nature are health seeking behaviours or manifestations of illness."

☐ Yes, I am willing to take part in the above study. My involvement, right to withdrawal and potential benefits and risks have been explained to me. I have had an opportunity to ask questions regarding the study and had received answers about my enquiries.

☐ No, I am not interested to take part in the above study. My involvement, rights to withdrawal and potential benefits and risks have been explained to me. I have had an opportunity to ask questions regarding the study and have received answers to my enquiries

Please print name: _____

Signature: _____

Date: _____

Demographic Information:

Age: _____ Religion: _____ Ethnic Group: _____

Years & Area(s) in mental health as OT: _____

Contact details (telephone number and email address please):

Appendix 4: Interview protocol

Before we start, I want to thank you again for being willing to take part in this study. It will be recorded to help me in transcribing it accurately. You can be assured that this is confidential and that I will be the only person accessing this recording for research purposes only.

- 1) So, this study focuses on how OTs decide about engagement in spiritual occupations are part of their clients' health seeking behaviors or psychiatric illness... even though it is not the focus of the study, **can I begin by asking you to tell me what is spirituality in a nutshell for you?**
- 2) Having said that about spirituality, **have you been in situations where you had to decide if the spiritual occupations that your clients were engaging in were part of their way of seeking health or their illnesses? Can you describe these scenarios for me?** *(Patient can be ill or well at the time and that it can be individuals or groups)

Prompt Qs:

Describe that person a bit for me?

What was the spiritual occupation of concern in the case?

Other Qs:

Is it always that simple to decide? Are there cases where you really had to spend time thinking about?

Now, religious connections are often mentioned in the topic of spirituality; what about areas other than religion? Have you been with situations where spirituality take a different form other than religion?

- 3) **Did you arrive at a workable answer in this case? How did you arrive to this point?**

Prompt Qs:

Were there any particular resources or people that helped in you arriving in this point?

Were there any knowledge, information or documents that helped you?

Where were these people and resources based? From within the team you worked in? From university? From other sources?

- 4) **How did you find this experience of having to determine whether your clients' spiritual occupations were health seeking behaviors or manifestation of their illness?**

Appendix 5 a-e: transcribed interview of all 5 participants

[note: 'A' represent the researcher – Ka Yan Hess (Anita) in appendix 5 a – e and names of colleagues and places had been changed to protect identities of participants as well as colleagues they mentioned – the changes are indicated by a *]

Appendix 5 a: Transcribed interview with Imani: 2010-01-19

A: looks like its recording, ok.. once again I want to thank you for willing to be part of the study. I really appreciate this. As you can see I am recording this interview, this is to help me transcribe everything as accurate as possible. Umm... You can be assured that this is a confidential interview, I will be the only one accessing these recordings only for my research purposes only.

So, if we look at the study focus, is on how OTs deciding about engagement in spiritual occupations with their clients in the psychiatry setting on whether this occupational engagement are part of health seeking behaviours or their psychiatric illness. I wanted us to... let us begin by exploring in a nutshell what is spirituality in your view for you?

IMANI: I think that spirituality is ... just the connection ... well it is the connection with something bigger than you. So it's either a connection to something we call God or it's mother nature or ... sometime it is just balance. Umm, and that spirituality is reflected in the rituals that people perform or sometime in the content of whatever they produces. Yar, so that's spirituality.

A: Ok, that's really quite nice cos' it quite all encompassing and umm very inclusive. Now, having said that about spirituality, have you been in situation where you had to decide... in some of your clients' cases ... that the spiritual occupation that they were engaging in, that whether it was part of their way of seeking health or whether that is part of their illness?

IMANI: In.. In... yes and no. Umm... There are some ... one straight forward cases. There are some cases especially where ... ah I am not sure it is just because I remember these... but when Muslim women used to come into the neuro clinic in.. at..at [name of workplace] and they used to wear full keejap (A: is that the traditional wear?). Yes, but the face scarfy included. And the thing that that was ...often ... ah ... ah.. it 's not conflictual.. but a bit of a problem for the therapeutic team cos'... how do you engage them when you cannot read their facial expression.

A: haha... that is quite...

IMANI: And that becomes the focus in the group the way they are dressed.... Ah... But what one notice.. I notice with the time they are staying in the therapeutic group is that... slowly the ... the... face covering

disappear and they might relax a bit more, u know... and the clothing becomes less so.... As perhaps when they become more familiar with the set up and feel more secure to let those things go... Um.. yar so ... that .. there were a number... one or two of those incidences in the neuro clinic. The other one is of course the patient that used to be at *[name of workplace A]* that had been transferred to *[name of workplace B]*. When engaged, he's... he's not really verbal... And umm... he doesn't speak English or Afrikaans ... ah and engaged a lot in hand gestures so whenever he see you he would like wave his hand like he was preaching ..ah... it turns out that it is preaching that he engages in ...umm But it's quite complicated to discern whether ... his way... does he see himself as a lay preacher (haha) or is it .. just... mimicking behaviour that he seen and there is not ... a spiritual aspect to it. Umm yar.

A: So, I think both of those cases are really interesting. We 've got in the first case with the Muslim ladies ... the expressing their spirituality in the way they dress ... which the team ... find a bit difficult to deal with ... which I mean it poses real challenges when one cannot read facial expression in a group context ... umm so as an OT and I mean obviously running groups with participants as such that are in the group, how did you engage them and umm yar because you also mentioned that there was a change with time. Those clothing ... became less and less ... as they have seen to warmed up with the setting.

IMANI: I think the first thing that was done by the MDT to say that, u know, to understand why it is that they need to wear the full keejap ok... and to explain to them that part of working in the therapeutic milieu is to let down your guard... u know.. and yes there might be men in the group ... but you don't have to wear the full outfit, u know, the... and this is where we draw on the experience of all .. of the MDT about what is appropriate and what is not. U know, umm in that it is... it is not compulsory to wear the whole kit ... umm (haha)... so they are requested in groups, not to wear the face scafy .. if later should they decide to put on again then that's okay but often ... it creates a barrier of communication .. part of being in the milieu is the improve communication .. umm.. so that's where it starts, is to speak to that person and say ok... we ... support what you doing, but you don't.. the.. the your religious rules allows a bit of flexibility and we would like you to be a bit more flexible here... And ... u know... you can then decide when you go home or when you socialising with the other patients whether you want to have your full kit on. Umm... but also everybody's expression of spirituality is different... ummm so the way in which we do or interpret religious ... umm teaching and tradition differs from one person of the same religion to someone else of the same religion. So, you also need to have a healthy respect for how people practice what they do and as you observe people in their practice, if they are consistent... ... it is more likely to be true to what they would do in a healthy state but it is that inconsistency , u know, that lead you to question whether the expression of spirituality is an expression of ... or whether the behaviour is a expression of true spirituality or whether is part of a psychosis ... umm.. or something else.

A: That's something that may disappear if ... when their psychosis or whatever symptom improves, so okay consistency is important.

IMANI: Yar, so it's during your interaction with them and also in the past.. so was it like this before? Has become more now and now that it is there is it consistent with the rest of what you do? U know, for

example a women does dress up in full keejap but she still does not act modestly that this dress is suppose to imply then there's something else going on. Yar...

A: Some conflicting messages coming through...you mentioned that was a team together having discussed this ...encounter.. trying to deal with this issue together... Can you go back to that memory to, just to give me an idea of what kind of resources or ... knowledge that people in that team were drawing on to have come to the decision together to... okay, let's speak to these women about this and trying to see if we can...

IMANI: ok, I am going to generalize a little bit that and say... it can be anyone any client that comes into the neuro clinic ok... and it depends on the background they come with and what cultural background they come with... whom we are going to draw on most. (A: ok.) If it's a ... someone of the Xhosa decent, they come to the clinic ... ok ... and they speak a bit of traditional healing and this is what they would do in their culture... one would check with someone in the team who has a similar background whether it is so. Automatically that team member becomes the expert which is sometime a bit of the problem... Because they are not... Some.. some of them may not necessarily be the expert in that field ... but you are asked question you are expected to almost be the expert and to know the answers to these questions.

A: So it relies on drawing on people who supposed to be of a similar... similar cultural background ..

IMANI: Yar... You know so the team were consisted of Dr. A*, very English, Dr B*, I am not sure if he is Jewish but he's got something of that (haha), there was Jean* who got the Xhosa background and a couple of others u know and you got the coloured background and they come with a bit of Indian. I was expected to be a Muslim culture expert which is a bit Yar.. hahaha not always... I didn't always know the answers.

A: Are there particular consideration that you would take ... when these ladies arrive with their full... either in terms of how you plan your occupational intervention with them, their inclusion in the group, are there special thing that you bear in mind for them?

IMANI: I think... for everyone in the neuro clinic is important to have a space. Whether it is a space you go share with others or whether it is a space you go and smoke ... For the Muslim ladies and some of the men, it was important for them to have a quiet space for them to pray. And then they, we would make ... they could either pray in their room but they need to consult the other...in order to express that part of their spirituality they needed to consult the other room members, the doom members. U know, to negotiate a time and space to perform their prayers and if that was not impossible they could use the group room but they needed to negotiate with the nurses in order to use the group room to do so. So they... either find it out ...staying there ... or they would... approach the nurses... It's one of those

unspoken rules sort of things, or they spoke to the nurses and it became explicit about the things you could do (A: and the others would join probably kind of thing?). Ummm... we hardly ever had more than one or two Muslim women at a time or one U know... The spiritual crisis for people who needed some space wasn't, it wasn't It didn't ... occur concurrently a lot and often ... u know the one would be more practicing than someone else. And that in itself create a lot of issue within... in a group. Ummm...

A: What kind of issue come up when there's someone more practicing than others?

IMANI: ok, we once had a guy who And I am sure that in ... outside he was very active in the church business... umm not business, church activities and umm...he wanted to bring the church to the ward. And umm, then... it became a bit of an issue in that... he became a lay pastor counseling ... u know (A: for fellow patients?). Yes, and he would bring his group from church people into what it... minister? And umm they have groups... spiritual groups, which ... create a bit of a split between the team and this outside church organization that's having groups in the same space. And a bit of conflict perhaps between medicine and spirituality... about space... hahaha

A: So, it's almost territory in some sense?

IMANI: Yes... But the ward can say, you are a client here you cannot be You got your own problems, don't take on others people's problem. And to an extent, that was true ... but also you cannot be an expert in my ... my territory... u know, haha.

A: So, for him, how did the team, you were part of team, how did the team deal with him, how was he spoken to about....?

IMANI: Well, this firstly having established relationship with his individual therapist, the therapist approached it first and ummm.. (A: therapist as in the OT or psychologist...?) No, the case manager. So, the team discuss what was happening and what must be done in order to manage the situation and the individual, the case manager then spoke to him... and the nursing staff... cos' after hours they would monitor the situation.. and the decision was that what he was doing was good and ummm when encouraged to getting support from whichever source to provide you with the necessary support to get through your issues ... but the ward was not the place to do such ministry. And if you want to come back after he had sorted out his own problems, then he could come back but not to come preach or minister to people in general in the ward.. he had to come visit one person.

A: So that someone almost have to identify the need ... (IMANI: yes) for him to come, he can't just come.

IMANI: so he was visiting a person, he was not visiting the ward afterwards.. and what one finds is that ... as soon as he had left ... and those patients with whom he had spent time started to being discharged, his visit also decreased ... umm which was .. it was okay.

A: is it.. for him, it sounds like ... he was trying to help other people using the way he knows about... umm and but he was sounding like as if he was doing too much ... and from the team perspective that, u know when you are starting to be running groups on top of the neuro clinic program which is I am sure has always been quite busy it seemed inappropriate or...?

IMANI: yes and no, it depends on the perspective you are coming from. Was this a defense? So, that helping others allowed him to avoid his own problems ... umm and he was there to seek help ... not necessary to provide a service ... would it be right for him to be providing that service? Also puts him into a different category to ordinary patient, he is the minister or the lay pastor (A: yes, that's a power ... step up). Yes, so it creates a power imbalance and one wonders how many things ... umm... the rest of the patients ... who ministered by him would confide things to him that they would not necessarily share with the therapist... case managers creating a split in the therapeutic milieu... u know, here's a patient who knows all these secrets ... and you may have comments in support group like.. I told you this or u know, you know about my problems so I wouldn't discuss it here. It puts... it creates a lot of secret and power imbalances and things are not open ... cos' the therapeutic team is suppose to sort out or assisting in sorting out the problems don't know what the problems are because (A: he knows all the problem). Yar haha

A: Nobody wants to discuss them in the group?

IMANI: yar

A: Going back to the other client that ...moved from *[name of workplace]* to here and you mentioned that u know... he didn't speak English or Afrikaans and not incredibly communicative in terms of being verbal but engage in in... some kind of gestures when he sees ... sees people in the ground in the hospital here.. umm... what's sparks off looking into ... what these gestures were?

IMANI: I think it was not understanding what it was because it was often very repetitive. Every time we saw him, it would be the same type of gesture but it wasn't appropriate to what's happening... like you would say hi, u know, waving your hand in a hello gesture and he would be making this ... (A: the same kind of...?) Yar, almost bowing forward and perhaps saying one or two words with that... as if he was emphasizing a point and umm I think... people were just curious cos' ... what is he saying cos'... he's not saying hello. Ha.

A: Just just describe him more for me so I get a better picture of him?

IMANI: umm, borderline to moderate intellectual disabled, looks a bit like your burnt out schizophrenia which he could really also be I am not sure quite what is the diagnosis. Umm very few words, umm yar ... and he walks around and carry a small bag... with stuff in it umm... so it is not necessary that he dresses up like a preacher, he dresses in the hospital clothes and looks like any other hospital patients. Umm...

A: So who..who... what's the process of finding out what these gestures were?

IMANI: it's trying to include him in groups ...and then he doesn't..., he not really engaging in the activities in the group but he would stand to one side ... or ...and sit quiet sometimes ... sometimes when he's not sitting quietly and engage in the hand movement and whatever he says. And I think that... a lot of the time in *[name of workplace]* wanted to pass that off as that's just that person's way because we don't expect great communication from our clients. Umm... I think years and years it went on where and and ... the patient got lost... he doesn't come to groups anymore, and it's okay, cos' the patient doesn't really participate.. umm then one day I was speaking to someone, I said like u know... haven't seen him for awhile, u know that patient that does this... oh yes u know someone spoken to him and spoke to him in Xhosa umm and ... and they listen to what he had said. And the person who could speak Xhosa said, u know, it sounds like he's preaching ... but also the notes in the file are quite scanty so one doesn't know whether that it's something he picked up from his original background.. or whether it is something developed later on as a perhaps Autistic tendency u know to engage in repetitive behaviour so ... is it spirituality? Doesn't go to church.... Hahaha (A: doesn't go to church?) he doesn't go to church u know so ... I don't know. Hahaha

A: So, yar that's a difficult case to think is it ... is it a health seeking spirituality or is it a part of illness spirituality? (IMANI: or is it neither? And spirituality... "softly") Umm and he stayed like this and he is still here?

IMANI: Yar, umm...

A: it's very interesting, for that case... It sounds like it's through inclusion, trying to include him in groups but it hasn't worked because he's always busy doing these gesturing these movements plus difficulty in communicating with him umm... do you... do you think you had arrived at a workable answer in that case?

IMANI: I don't think we have arrived at a workable answer ... umm... if workable you mean by is this psychosis is this health seeking or is this his way of expressing himself spiritually. Umm... we don't.. I don't have the answer. So... it just continues, and he just do what he does and it seems to make him happy. Umm it is not problematic... in that it needs to be addressed or some intervention needs to take place. Umm he doesn't interact in... ummm society outside where it would be seen as very odd because there's a lot of odd things happens around here so it seen as more acceptable.

A: And he's a long term person here? (IMANI: exactly). And how, it seems like a... unfortunately seem left hanging whether we like it or not, because it's almost difficult to, the behaviour is there and it is ... I mean you did mention early on that one would look at if it is consistent so in this case it is interesting that it is kind of consistent ... he's always been doing it but it's not easy to understand, it's not You can't almost tell it the one way or the other.

IMANI: I mean there is consistency and there is appropriateness... You know, so yes his behaviour is consistent but it is not appropriate. It's not appropriate to when you say hello to someone and does the preaching thing to you... so, one needs to take the two into... it goes hand in hand to decide whether the behaviour is appropriate or whether it is suitable spiritual ... not suitable (softer) spiritual ... but Whether it is a spiritual expression that could indicate a psychiatric illness or whether it is just their ways of expressing themselves.

A: we spent a lot of time talking about the Muslim ladies case and his case where it's linked quite predominantly with the connecting to a higher being ... some of us of which may call this person God and in your definition of spirituality you also mentioned umm... about the other ones, where you know it is something bigger, it doesn't... it can mother nature... it can be other things... are there other cases that you came across... speak to any of that? You know, something beyond the religious...

IMANI: I think it sometime just come down to just u know, as I mentioned earlier on that sometimes spirituality and balance goes hand in hand. And umm in the neuro clinic, where you often find women who had been in traumatic situations who angry at God but they need a balance. So one would try to engage in what... u know... relaxation exercise in order for them to ... get that balance again.

A: And it's about?

IMANI: It's about that connection with... I don't know what it is but it is an inner peace. Now, does that peace come from God or come from nature.... ... Of is it something that comes through your connection with yourself? Umm it is not clear. But yar, it's... ... yar... it's difficult to say... hahaha

A: Yar yar, so... yar, there's also... Cos' I am quite interested in ... spirituality as balance... I think that's something that it's not been said often... spirituality and balance and that some occupations like you mentioning... like relaxation Could potentially speak to facilitating some of these connections and address the balance issue.... Umm is it, when you choose whatever ... group activity that umm you engage with the group with in that context... always going to be relaxation? Cos... that or how do you choose? (IMANI: for spiritual?) yar... the balance bit that you are looking about.

IMANI: In the neuro clinic, there is the intensive say .. psychotherapy groups and ... you have the more cognitive life skills groups ummm and there would be your relaxation group which are standard ..., a set. In additional to that, the clients were encouraged to do leisure activities, so either like hobbies what they brought to the wards, there's a garden outside that can be maintained or to take walks on the premises. But they also went home on the weekend and people would go to the beach or take walks there or walks in the mountain although there was a guy there who walked on mountains because that was his way of coping... umm.. u know, so the leisure activities were to encourage a More healthy activity but not necessarily spiritual activity. It is what you found in those activities... or what u... what people got out of those activities differed. And someone just didn't took on gardening and just they came here to get better and not to work on the garden. And that's okay... but other people really enjoyed it they took on strips, u know, or they took on projects in the garden, and that was their way of doing things. Other people took on bit of gardening just so they don't have to interact with others, u know... it was all about the purposeful engagement of the activity and it may not have been for ... balance or ... for spirituality.

A: do you think that ... sometimes that spirituality isn't always an explicit thing that is on the table ... Being an occupational therapist working in the mental health setting, is it implicit and where where would it be if it is, where would it be implied?

IMANI: are you talking about the type of things that are set up in the ward or activities that you would provide for clients?

A: Ummm... I think a bit of both but I think more... I would be more interested in the activities u know as OTs we are more closer into doing with the clients.

IMANI: well if u know at the rules of the neuro clinic is that we do not debate religion or politics, ok. And... even through our clients and clinician comes in with their own spirituality, their own religion and their own politics..., we try not to make it explicit in our interaction... umm coming very much from the medical model from the very Western model or the scientific model of it all..., but... ... the new democracy... you also need to respect where people come from and what they believe in as long as what they believe in doesn't ...umm cause harm to the system ummm so people need to make certain compromises. (A: people as in both?) Both sides.

A: Yar, the clinician and ...

IMANI: Yar, so your Rasta man can come in but he is not allow to smoke dagga on the ward ok... if he does it.. or sorry in... while he is in the program even through that what his religion entails... (A: would entail him to do?) Yes... And it's known that when you come into the program there is certain expectation and you buy into that...

A: So, ...just referring to more the dagga and the Rastafarian, because I think that's an very interesting example of spirituality that it's not ... encouraged or allowed to be engaged in more for the system.. the sake of the system rather than questioning whether this is good or bad for this particular patient's umm...

IMANI: haha (A: cos' that is debatable there...) yar it is very debatable whether cannabis is good thing or bad thing for one's mental state and it's good for some people and it's bad for other people. Who do you decide it is good or and who do you decide it is bad for and if you for good when you doing it in the ward ... someone else who it may be bad for may be encouraged by what you do, you know and then they got into a habit while they are in a therapeutic program or they on a ... u know.. they just gotten off drugs they just been clean and they are there for the therapeutic value of the program and ... (A: and someone the next door neighbour is smoking...) hahaha so it does create a problem for the system umm in order to protect the system that expression of their spirituality or religious belief ... would be religious practice would be 'catail'. But umm...

A: I am interested because there is this explicit rule of not discussing religion, politics and ... there was something else...

IMANI: no, it's religion and politics, yar

A: the two, but with your one example of the lay preacher who came for help but end up offering help to everybody else... so it came up even through there is explicit rules... it seems to be.

IMANI: But the rule is there to stop us from fighting about who's right and who's wrong and who's beliefs are .. superior or take presidency in the situation... because in the ward, the ward rules presides...ok .. (A: above?) ok, above everything else... and if you cannot fit into this and we are reasonable and we will enter into things... we will try to be flexible about things but if you cannot be flexible on your side then perhaps this is not the place for you... so it ... it can to a certain extent act as a bit of an exclusion criteria... but it is also something that helps to contain and maintain boundary.

A: Does the rule has something to do with the nature of what the problem is for some people to comes in with rather (um um... 'no') or... how are the rules decided?

IMANI: The rules came about because of the diversity of the groups that comes ... umm... ..and often when people are sharing about themselves they need to explain where it is they come from .. and we all come with biases and we all come with preconceive ideas with what others do and say.. umm and sometimes that sharing of those ideas ... umm... can lead or can lead to some exposures to something that are inaccurate or others may take offence ..to so we try to avoid the discussion of of religion... yes it is important yes it gives you strength it gives you we acknowledge ok... but yours are not better than anyone else's. Just because you are more... you express your religion more than someone else it doesn't mean they are not as strong as you are in the... u know.. we all have different life experiences and in the end we are all equal...

A: So, ok so I guess that the religious aspect of spirituality would definitely be ... be at least in the rules is out? It's not something we discuss in the setting here and things like that. And umm and things like that. But if we looked at the ... you know you actually already mentioned the connection with self when one is engaging about balance and focus.. your example of relaxation ummm that feeds towards that... how about ... aspects where.. u know where the nature.. u know you also mentioned about the hike and the gardening that happens in the ward or outside in weekend. What about connecting u know with each other u know ... cos.. umm... ... in the ward?

IMANI: In the neuro clinic what is nice is that everybody for longer period of time than in the acute wards so they are able to establish a certain bond and build trust and they do share a lot with each other. What we do find was a split between the smokers and the non-smokers. So ... what would happen is that you would have a support group and the smokers would after a support group go to the smoking group to go and have a smoke (A: extra support group?) yes. While your non-smokers who don't really want to be in your smoking room were excluded from that. (A: extra bit of support from this peer support?) They would sit in the tv room, a more open area umm... so there could be strong bonds between smokers and ... the non-smokers. And... .. yar, so that was informal support seeking from each other. And the connection with people perhaps did break down the isolation that they might have preceded or been there when the symptoms of depression for example were hectic. And... .. it's probably very similar to the comrade experience of church group or a church circle... Umm..... in a certain, to a certain extend the wards rules of confidentiality helps to protect one within that relationship and you also know that in most cases you wouldn't see this person again.... (A: so after the 6 weeks or however many weeks of being there?) haha haha.. So the connecting is artificial, it's deep it's real but it's ... (A: also only momentary?) yes. For a lot of them... Occasionally they may enter the services again later down there.. haha.. but you know it will be one or two in a group of new people. Umm... so to a certain extent the connecting to others does happens umm whether it is a spiritual experience I am not sure (softly).

A: Now, I think we have talk about quite a few different interesting case where you were part of the team where all of you have to deal with... together some some issues that are related to spirituality

umm.. for you being the OT in the team, how did you find the experience of having participated in part of this decision making umm... process?

IMANI: I think sometimes to be called on as an expert is problematic for me... ummm, it's just... it's probably very similar to asking a u know, someone who can speak Xhosa, a team member who can speak Xhosa to speak to or translate for a patient who speak Xhosa. And you might not necessarily be the best translator, you might not be the person who really grew up... you might look it and have a name but you might not be from that cultural, u know and have that background and all... know all the rules and regulations for a religion so umm... that is slightly problematic, luckily most of the patients comes with the basics so u know... that you are relatively covered hahaha so ok that's normal, that's not so normal and I am not so sure about that... so you able to answer those questions but I don't know whether my colleagues also had similar experiences ummm... I think it is sometime it's lucky, u know, for example the Christians there would be like two three four Christians so they can back each other up or check on each other and things.. but yar... so yar that was problematic. But what was nice was that, ..it also highlighted the different background we came from and despite that one could get along u know one would come up with one plan to deal with that patient, instead of having many many different plans. Umm but it also helped the team to understand where the client was coming from ... who's umm... u know, people would say my clients say this umm... what do you think? And then you ... add or you help them to understand what it could be that the client meant or where the client would be coming from.. umm... And sometimes.... If you are unsure about an answer around religious expression or spirituality umm.. and you would you would say something like you are not quite sure of whether that ... it was right then the case manager would go back and say is that clearly so ... because it is sometimes it is a belief that ... the client has but it is not necessarily the fact .. u know, this is the way things should be, and then u know is it really the way things should be. u know where go back to why you think this is the way things should be.

A: So, it's sounds like it is uncomfortable to be seen as the expert and having to answer all these questions. And one obviously only come from your own subjective point of view of what you know and what you know and experience may not be part of what the clients know and practices. And but at the same time to me that it is also great to have other people to draw onto as resources.... Ummm now u spoke a lot about people as resources what about umm ... u know more more ... I am thinking of more... are there particularly u know models or knowledge base that are or were particularly helpful at all in any of these situations? U spoke a lot about people with backgrounds are good resources ...

IMANI: Umm... umm I am not sure about models what works works. I am not necessarily someone that ... I can't remember models so well ... so I am bit more of a gut OT hahaha... And ... the other experts one would draw on is... especially you know for the Muslim client it would be the MJC, to give them the legal advice to help with divorce procedures (A: what does the MJC stand for?) Muslim Judicial Council. u know if they are busy in the divorce process to assist them on that because of whole women's rights in Islam and things umm like that... And then, I mean also most of the time Christianity basis would be covered cos' people knew enough and able to... (A: So also organizations can be draw on?). Yes, Jewish board of guardians yar... So...

A: And the gut feel?

IMANI: Hahaha (A:Cos I think one cannot underestimate... especially in psychiatry we always talk about this transference and counter transference and) You know the gut feel, my whole philosophy if it works for you and it's working for the people around you and/or it's not interfering with the people around you then it's okay. Umm... ... And that's my model hahaha haha, umm... ... I think ..it's also where I come from and what my life experience is umm... that's hopefully had made me a little more open minded. It's certainly made me more flexible than my parents .. about spirituality about what is appropriate and what's right. To a certain extent it's probably also about my experiences in psychiatry and Western training u know... that has contributed to my way of seeing things... ummm.... Yar so that's my... the model of my gut hahaha

A: I think that's ah ah something really interesting cos'... u know.. we ... often what we know isn't always in our head umm... and like I was saying the counter-transference transference u know that has been talked about as something to that extent. And you know in psychiatry that is particularly interesting as well. Thank you very much for your time and sharing of the cases that you have spoken about just now umm I really appreciated it.

IMANI: Thank you Anita. It's always useful to think about these things. What is my model? So what models are there? Hahaha

Appendix 5 b: Transcribed interview with Jose

A: Once again, I want to thank you for being so willing to participate in this study and as you can see that I am recording this interview to ensure me for transcribing after we are done. And you can be reassured that I will be the only person using this for my research purpose only.

So the study focus on what ... on how OT decide on engagement of spiritual occupation as part of our clients' behaviour whether it is part of health seeking or whether it is part of their psychiatric illness. Before we start, I just wanted to ask you maybe to put in a nutshell what you think is spirituality?

JOSE: ok...to me spirituality is ... umm the way how a person feels about about... I think their higher being, are they.. how they feel they need to connect with the higher being so it can be through prayer or living a specific lifestyle or yar... that's basically it.

A: So, having said that about spirituality, have you been in any situations where you had to decide or help your clients with their spiritual engagement in occupations or expressions and yar just want you to describe some of these scenarios for me.

JOSE: ok ... basically my idea of how ...how spirituality works... because I am Hindu and I am from Durban [so] it is completely different culture to what I work with here. The two main things that I have seen here are.. that's people dealing with how they connected to their spiritual being is the Rasta's that I have seen practice and there are people I think called Twasa or where they become sagoma. So the one lady I had was going through that process, I have to deal with her... she was 35 years old, she was a nurse, she worked at a medical aid office where they approve medical aids, I think it was for discovery. And... She was acting strangely. So apparently when you going through this process, you have to do rituals at night and drink a certain beer or something and just all the stuff...staying up late and drinking this certain... whatever she was drinking and I am sure if she was smoking something made her act strange at work. So we have to decide whether this was illness or whether this was really her [A: really her going through this process?] yar. Through what we found out was that while talking on the phone approving their people's medical stuff, she would blurb and she would blurb loudly (A: into the phone?). Into the phone but they sat in cubicles (A: Right.) She would blurb loudly that the whole room would hear it.. It was... they said they even counted it to be 40 a day .. yar (A: would she blurb once into the phone call or kind of...?) She blurb during phone call and she would say oh I am so sorry I am going through this right now and this is what we do... ah if you .. there is a Xhosa speaking people you would understand. She will tell them that.. Her.. Her line manager was also a Xhosa male and she gave him a hard time because she said you are a black man, you understand you understand the culture. (A: so you suppose to know what this is about?). But he also know that this is not normal through as well. But on top of that, she would drink litres of coke a day. So it also make the blurb more. So we had to, what we did was... we spoke to our Xhosa women around here and whoever we could speak to here about it and they told us no they do go through rituals but and they compare what her behaviours to what she was doing what she was saying and they say no... this is .. not right, yes you are suppose to do the rituals you

suppose to have the dreams and umm because she said she was not sleeping or she slept badly because she had these dream of people (A: and that she had actually been up and doing rituals?) yes yes, so that wasn't normal. But there was conflict with the staff this patient very high functioning, worked in England came back and u know, she worked in psychiatry a lot. (A: yes). So she knew how to cover up everything. (A: So she would know all and how it works as well...) Yes and she knows the language. So she would say... she will tell you things in a certain way and why she did a certain things I can't remember exactly what it was. The nurse would believe her because she manipulates them in a certain way and they would come and fight with us. It's like why are you keeping her, the family needs to take her, I think it was the Eastern Cape and go there to complete this and then ahh... we would say but this is what her boyfriend says. She had a boyfriend and he was the one who brought her in. We had to determine also who's the next of kin – who's the person we cooperate with and with for respective amount of years and whom she had a sexual relationship with is the next of kin. We had the family at our door steps fighting to take her out to the Eastern Cape there is something wrong with her. (A: they believe.. did they believe she was going through the process or did they believe she had a spiritual problem that needs...?) It was a combination.. yar, they said there is something wrong that's why it's going wrong now. So we need to take her to the Eastern Cape to sort it out and she will fine and she can continue with the process.

A: so they intending to take her and they were going to bring her back (to the hospital)?

JOSE: We don't know that. But the fact is we saw her taking to herself and she was saying things like really grandiose about how beautiful and energetic she is and the world cup comes around Cape Town is going to be so filthy that she's going to go around cleaning Cape Town things like that (A: sounds almost a bit obsessive so one to say things like that). So we had to determine... ok.. we also got collateral from the boyfriend ... he said she's not sleeping we saw her talking to herself she 's acting strangely at work. And all of this started happen when she started drinking this traditional beer and also happened mainly around when she had a car accident and she had a slight head injury even through nothing was shown on the CT scan.

A: and how long ago that before this episode?

JOSE: was about a month.

A: this is a case kind last year

JOSE: Yar last year. Yar, so she had .. she was here in October..November 2009. She had the accident in around August something.. she was in hospital then she was hospitalized for what they thought was a manic episode and they gave her Epilium. She refused Epilium because she say it's for people with

Epilepsy and she doesn't have it. So, she stopped it and the boyfriend eventually brought her here. She stayed about two months and then when she was well enough we sent her home.

A: Now, in your process as her OT working with her including her in your program; what kind of umm.... Groups had she come to you or what kind of intervention with her?

JOSE: Basically she had to slot into the program, the intervention well group wise she had to slot into art and craft and life skills... ahhh like the day planning mainly. Individually I had to sort things out with the employer so we had to go through the process – was she a permanent worker, does she have sick leave and I had to sit down and speak to her about that this is what the collateral had said that you been doing this and this, can you put down on in it. Can you imagine how your colleagues feel? So yar, it was kind of... in the beginning you couldn't really reason with her because she was really ill but towards the end when you kept saying this kind of things she came to it. She understands, maybe she should cut down on this and cut down on that.

A: but she's still determined to go through the process at the end?

JOSE: she still was..

A: so this is... this is very interesting cos' this is a psychiatric nurse or well at least a nurse with a lot of medical background that would know about psychiatry. Someone who comes in very high functioning... now we mix it with a bit of cultural spiritual practice that are local to us here and Umm That there was a process of using collateral from varies different people as well as looking at her behaviour to actually say hold on is this illness now or really part of the process she was talking about.

JOSE: I mean my role was mainly to get the collateral from the boyfriend which I adopted but mainly from work like how she function at work, how many hours she worked, what was her productivity like and from there we could see.

A: Now, it sounds like based on the information you gotten; you decided not to engage with her on the aspects of the ritual and things like that she was doing. Umm what helped you in making that decision of not engaging with that?

JOSE: As a rule, from what I have seen with the patients who are grandiose whether it is Christian or Muslim or whatever; we.. when we have a group, we stay away from the religious because once it starts it goes on and on and on....

A: Is this a blanket rule for everything?

JOSE: yar yar (A: so it doesn't mentioned anybody coming in with whatever? So it's a blanket rule.) Because we have a mixed group, some people believe in God some people don't believe in God or different Gods living different lifestyles. So to avoid the politics we keep it out as a subject. One on one, I would listen to her but I would not they says it's wrong cos' I don't want to challenges her that time. So I just listen to her. As time goes on she started to make more sense.

A: So you kind of have to wait for the right time to challenge, how did you determine when is that right time?

JOSE: towards the end, when everyone say she's stable she's not talking too much, energy level lower and I saw how she engage in the group [and] one on one, with good eye contact and made a lot of sense. So we said [to her] what is the story now? Are you going to carry on with the process? Yes. Are you going to go back to work? No. Because that she feels that she had damaged the relationships there. In the beginning it was they don't understand me I am going through a process u know but they should understand me. Now it was I understand what I did was wrong and was too much and I damaged the process umm the relationship.

A: so she actually didn't end up going back? [12:32]

JOSE: No..

A: did she went on ... to the Eastern Cape?

JOSE: Yar as far as I know, I don't know about the Eastern Cape but I know she wanted to carry on with the process because her grandmother was also a sangoma. So...

A: So there is a family in some ways ... umm at least at face value there is some possibility that this may be real...? [JOSE: Yar] What did the family say cos' they seem adamant that this was a real process?

JOSE: Well they were angry that he... that we allowed the boyfriend to certify her and he is not family and who gives us the right they are taking us to the lawyers. We said no, but he is the next of kin and

we... this is based on what he said cos' he lived with her and the family didn't. They lived about 300 kilometers away from her and they would see her I don't know once a year twice a year and she would need to drive up. And is also... there is a hidden agenda because now they thought ok she's ill she has a car there is sitting somewhere she has money we can get in we have to weigh up those factors as well. So we had this guy who comes in and taking...

A: that I am coming in and taking care of my family member and you guys must have nothing to do with it? [JOSE: yes yes So, I think in that sense, umm I think the team and as the OT part of the team that you guys played a protective role in terms of that?

JOSE: we have had... In terms of the male wards we have in terms of they want to take them to the sangoma because the family believed that this person is bewitched because they are hearing voices and acting strangely. And the team had to intervene and say no but you can't bring your traditional medicine here and no we are not going to get them go for a weekend to this place and come back. You wait for them to settle, once they settled you take them and do whatever you want.

A: Ok alright, and just for curious sake, in terms of diagnosing this nurse her do you remember?

JOSE: oh.. she was schizoaffective, first it was substance induced but she was eventually schizoaffective. (A: that she had probably stayed long enough for you to see?) Yar yar so she was schizoaffective.

A: And the other one, haven't ever hear of ... oh no, it was the rasta one..

JOSE: Oh the Rasta one, we get lots of Rasta. (A: truthfully or the disguise ones?) I don't know how to tell them apart. You have the one that come with drad's ummm.... Eventually you will be able to negotiate cutting the it off because of hygiene purposes. But we have had people who said no, you can't cut my drads off this is my culture... u know but they would negotiate to keep it clean. It's always negotiating. In terms of dealing with the Rasta the whole big thing about smoking... gunja. It's not a drug to them it's a plant (A: a herb?) yes yes it has medicinal value and how dare we say that. So then, what I normally do is that I print out stuff from Google, tell them what gunja is and what is the effect it has on the body and explain to them how some people may be able to smoke it forever and nothing will happen to them but people with mental illness... they can't smoke it (A: that it's a very bad idea?) yup yup.. So we never..sometimes we get through to them but they always fall back at times to it's my culture. We have one guy now with talking he says he's Rastafarian he has the long drads he is 21, comes in with substance induced psychosis slotted into our dual diagnosis team and we educate them about substances and stopping. And he tells other patients he will do this for a year but next year he's going to start smoking again. (A: he will go back?) Yar yar so then it's just education about substances and about the illness and the combination so yar...

A: So I mean sometimes it is quite difficult when someone is so adamant about their choice?

JOSE: I had also done some research on Rastafarian and found out that it's more about them being against the society that explain the hair and their clothes and [A: being free almost in a way?] Yar yar. And smoking gunja is not the only way connect to God ...

A: so what else did the literature did you found?

JOSE: oh, cant remember now. It was basically living this life men you need to be vegetarian umm you have to.. basically you have to live a certain life it mustn't be..

A: a lifestyle, particular practice of a lifestyle?

JOSE: Yar yar so but...

A: have you ever throw them with the other options? You don't have to smoke gunja that Rasta look.. there are these other ways that according to other people said u know are possible?

JOSE: Like?

A: No, I am just saying ... because you were saying that you found some literature that there are some different lifestyle way. Umm

JOSE: Yar but but that's what I said to them that the way you can show you are a Rasta without smoking. That smoking is not the only thing that defines you as a Rastafarian.

A: Although there are some of the cases that I dealt with as well that the smoking part seems to be such a big thing..

JOSE: Cos' it helps them to focus ad mediate and connect with Jah. ... I don't know... I always have my reservation about it but if that's the way...

A: [Is it] because the link to mental illness [JOSE: yar.] and obviously their choice of engagement..... And.. ok, seeing that you worked in female and male before, is there such a thing as difference between how men and how women may engage with spirituality?

JOSE: umm... not really. Female often has more umm they seem... not more spiritual but a lot more romantic view of spirituality of that make sense.

A: describe it a bit?

JOSE: like... I do this because it makes me feel good and makes me connect to God... it's more emotional [A: like it's something more inside about almost... something about connecting out and higher there but something also coming back to the inside?] Yar, with the female I found it's about how I live my life that I can connect and it's not what I have or what I get back. With the men is more about what I get back. Like with the females I haven't found any Rasta's ... actually I haven't met any Rasta females before but with the male it's a lot more I am a Rasta I get to smoke. [A: like I got a license to smoke?] Yar yar that's what they get back from it. With the females it's like I am giving more of the... [A: the receiving than the giving?].

A: I think we spoke about two cases where spirituality is definitely being link to I like symptoms in the traditional healer's case, although a appropriate process of becoming a traditional healer do exist; that person didn't seem to meet the criteria and on top of that there is seemingly other strange behaviours that we understand as symptoms. Umm and in the Rasta's case, there is obviously the very strong connection between using drugs and relapsing which makes it a really... it just seems to be just a health hazard .. a spiritual occupation for the patient to be continuing to be engaging in. Are there anyone that you have experiences with ... ahh where perhaps it is more neural or potentially umm health giving to that person?

JOSE: No.. not that I can think of.

A: Do you think perhaps the context where you work at influence on it? I mean obviously it being fast and...

JOSE: Yar, if you look at our catchment areas, these are kind of areas where drug is prominent and low functioning people uneducated people ... So it's very rare that you would see like a high functioning with like an Earth child person who does this and this and this. [A: wait for the fruit to fall off the tree?] Yar yar and take this vitamins and that vitamins and this combination give them something. U know ... I haven't seen anyone. I have had one person who is likely a kind of a hippie person but she is not a self proclaim Earth child but believes in the [A: the mother nature and..?] Yes yes And what she mainly want is to take a vitamins lots of vitamins and drink lots of water. But she wouldn't just drink water inside from the inside taps she will drink from the outside taps as that is more holy connected to God Mother Nature [A: connected outside?] And it tasted better but I am pretty sure that's not the case.

A: ok, so she was one of the female patients here?

JOSE: Also from very high functioning from a very well off family who also did a lot of drugs and did some prostitution and stripping and stuff like that. [A: the same person?] And she eventually just decided just like she's a free person and she's connected to herself, connected to Mother Nature so she does this kind of these things. But she still wouldn't give up the smoking and it's a battle to give up the drugs but she was connected to Mother Nature. So there was a bit of contradiction there, wouldn't they all be nature? And that she wouldn't smoke gunja because it is disgusting.

A: that's the explanation she gave you? [JOSE: yar]. So she wants to connect with Mother Nature, but at the same time she also smokes and do all the not so.. [JOSE: Mother Nature type of things]. So it's about a contradicting... I mean I am just picking up from the three cases you talked about perhaps is contradicting behaviour are an indication of this is probably more towards the illness side?

JOSE: exactly but I.. in my mind it seems like they know these things that's happening and they have all these thoughts and they have to find some basis to it.. Something solid like I mean like most of the Rasta's I come across they smoke not only because... they say it's because they are Rasta but most of the time it's self medicating – they are too anxious or it's the voices you know something. They self medicating.

A: So Rasta's are more of a mask of...

JOSE: of the reason why I smoking but not the actual reason.

A: so you almost saying that perhaps actually trying to find a spiritual explanation to [JOSE: yes] why we experience a certain symptoms are part of the... part of some of your clients what they are going through [and] experiences. To try to find an answer.... I mean psychiatry... I mean there is a lot of ...

JOSE: We see it one way, a lay person wouldn't.

A: Now, you mentioned a... obviously there is a team involved and you as the OT is part of the team. How did ... I think particularly in the nurse case where you describes there were nurses involved and they couldn't understand why other members of the team is holding this person back umm... what kind of discussion went on to actually eventually decide that ok we would actually not engage with her and this kind of self identified spiritual journey?

JOSE: we told her what the collateral was this... [A: so you told the nurses?] Yes because we are all one team at the ward round at the time and they didn't know what the collateral said so... We told them... I told them that the boyfriend that I saw was actually saying this and this and work said this, so what do you think? So they were like, oh she didn't tell us so that clear it up.

A: Was there also a bit of personality involved with this case?

JOSE: Yar yar I don't know what kind of personality I can't remember but I think it was more...narcissistic traits

A: Now in these three cases, a lot of them focuses around that of a connection to a higher being which is the way how for yourself that's the way how you see spirituality yourself. But you also mentioned that the spirituality that people engaging here is different to what you experience from Durban, from Hindu background. How do you work across... u know... obviously we all human and we all come from our own subjective perspective how do you work across?

JOSE: I haven't been a very good kind of Hindu? So I come to work with... well I mean not that I am not a good [A: u open minded?] Yes I don't come with I am Hindu and this is how I think. I look at the person and look at their context which is how I think we are taught to look at before...

A: so a lot of actually checking of the context, the person's previous context, behaviour... [JOSE: and what other people think in the same context]

A: In the three cases, do you feel that you had arrived at workable answers to all of them? Or were there ones where you feel actually I was not comfortable with what I ended.. the answer that you came up with whether it's health seeking or whether it is part of the illness were didn't work so well.

JOSE: Most of it was part of the illnesses and not health seeking.

A: seemingly straight forward that it is easy to look at?

JOSE: I mean like it all sounds delusional because like the women with the outside water only, it all comes from the same source so it wasn't bore hole water, it [the tap] was just outside.

A: it was more a bizarre explanation why she is behaving the way she is?

JOSE: yar

A: And umm in terms of resource, what and who do you use when you think about these cases?

JOSE: well the internet, Google is my main one and yar just look at what the textbooks says, with those spiritual stuff and the cultural beliefs and then ask my colleagues.

A: colleagues in the team or ..what would be your preferences other OT who are probably isn't as involved in the case or ...?

JOSE: I use them to... if I feel that I am not entirely satisfied with the answer that I got here. [A: from the team here?] Yes.

A: you mentioned textbooks, what textbooks?

JOSE: it depends on.. yar yar I haven't use textbooks for those two cases. I used Google.

A: When you are on Google, what kind of things were you looking for? What kind of things were you searching for?

JOSE: The Twasa thing, [I was looking for] being a spiritual sangoma. The Rastafarian I just wanted to understand it.

A: so you just wanted to understand what is the normal process of becoming a traditional healer and what would a let's say true Rastafarian would look like. Ok...

JOSE: yar... and why they do what they do because obviously they don't do what we do. We have a lot of the patients with the long nails and refuse to cut it and big hair umm they needed to do drads and you know they were dirty so I needed to understand why ...

A: that u know, one may be a Rasta but one don't have to be a dirty one that perhaps also one can be a clean one that cut your nails and keep your hairs all together?

JOSE: yar but apparently that's not the true Rasta. The true Rasta don't do that

A: it's not free enough?

JOSE: yar the society want you to cut your hair and look neat.

A: Who says that? I mean according to who?

JOSE: according to general society.

A: oh ok and also umm how do you find these experiences? How do you find these experiences of making those decisions? [JOSE: what decisions?]. Umm to having gone through the process of having a case in front of you who come with seemingly spiritual expressions spiritual engagement of occupations and you having gone through to the internet and look for information... in terms of the experience of the process, how do you find it?

JOSE: Just like going to the process to determine whether it's health seeking or not? [A: umm] I look at how the person is now and I look at premobid functioning umm what they were doing before and how were they coping and like ever since they used gunja what happened and like basically how they stay their day, I look at if it's more balanced or not? Does gunja make them zone out so much that they have

to sleep the whole day and they are 20 years old and they could work u know. So it just weighing up all the option.

A: so you look at premorbid functioning, you look at umm almost their developmental stage and what they would have normally be doing and the effects of what they do in how they impact on their functioning on how they match developmental stage as well? Was it an easy was it difficult process for you to look for information or ask for help dealing with these cases?

JOSE: yar. I think looking for premorbid is not always the easiest because umm parents don't want their child to seem dumb so they say oh yar they did well at school ok what marks did he get, 42, 43%. But he passed. So u know that kind of thing, or they came close to passing. So..

A: now being the I don't know if there is other Hindu people in the team, umm do you ever kind of get to be the expert if there was ever a Hindu case coming through?

JOSE: yes we have one now... umm Someone now she's not Hindu she's Christian but she has an obsession with Durban and India. And she's not Indian but she ran away to Durban years ago. [A: this is a current case?] Yar current case she's in the ward now. So she believes that umm people at the temple they love her, I can't remember why and they gave her a name they decided.... [A: a different name?]. Yar a different name, her name now is an English name and they gave her a different name [A: is it a Indian name?] It's a Indian name but it's not a Hindu name, it's a Muslim name. But people at the temple wouldn't give you a Muslim name because it should be a Hindu name and people at the temple don't give you names anyways, your parents give you names. And she also believed that [A: almost sounds like a born again kind of concept?] You don't really get that umm yar. [A: which you get in Christians?]. I mean if a Christian person what to become a Hindu it would be their choice to change their name but they would still keep their name and still practice Hinduism.

A: Who would give you that name or can you just pick one yourself?

JOSE: Well normally the way we do names is when the child is born we go to the priest and it's called the book, I don't know what the book is called everybody calls it the book. They look at your star sign they look at what time and stuff you were born and the month and then from there they probably gets to determine the first two letters of your name.

A: first two letter of your name according to the signs and the current..?

JOSE: yar.

A: so tell me more about her through, so she was obsessed with Durban and she now has a Indian name.

JOSE: yar but we call her by her real name. [A: and does she respond or does she get very angry?] Yes, no no she will ... it's more like a ... that's my name but everybody else calls me this. U know, she's bipolar so she's quite happy person [A:but she's kind of more manic or hypo-manic?] yar, so one day she comes to [me] after the group session and after the session she comes to me like are you Indian? And I am like yes and she's like are you Hindu and I said yes and [she said] u know I was in Durban I went to a temple and they gave me this name [I said to her] but that's a Muslim name, that's weird and [she responded] oh is that a Muslim name? And [I said] yar ok and she kept quiet there and then she says I love Durban [and] you know Gandhi bought the whole of Durban. So I am like really cos from what I know Gandhi was quite a poor man and... [A: couldn't afford all the Durban...] he fought for the rights of Indians but I don't think he could have afford ...[A: he wasn't a business man who would go and buy...] Oh ok.. then she keeps quiet. And the next time in ward rounds, I hear she doesn't talk about those things anymore. haha

A: so she obviously have enough insight to say oh she doesn't really quite buy my ideas? And does the team check on you then in that case in terms of Hinduism and..

JOSE: they just look at me and say what do you think? And I think nonsense

A: and [is it] a pleasant or unpleasant experience being the 'expert'?

JOSE: [sigh] it's kind of unpleasant because it's kind of I am not the expert. I am probably the person that is Hindu that knows the least of my religion. These are things I never paid attention to as a kid cos' it was forced onto me so I blocked it out so... So, when people come and ask me about Hinduism I wished I had the answers but I actually don't. But from what I don't know I Google it. But I know some stuff like name giving...

A: that it's a big one and an obvious one now that it doesn't happen?

JOSE: yar

A: are you practising?

JOSE: Hindu? Yes I am kind of.

A: cos' you sound like as if you are on the edges of

JOSE: yes I am I do all my rituals and I fast on all the days I am suppose to I just don't have a lot of knowledge about it. There is a lot in Hinduism that I know why we do the rituals but there is a lot in Hinduism that I should know but I just don't know

A: ok so she was bipolar and still here bipolar and have some kind of, I think, very unmatched cultural swap like she was not Indian and she is a Christian and at least she think she was a Christian and for some reason she decided now that she's Hindu? Does she even say that or is she just obsessed with India and Durban and not necessarily the religion?

JOSE: yar

A: It's just more like I really love India and I love Durban and I went to the temple. (JOSE: Yar). Ok.

A: Are there another resources [or] people you use?

JOSE: well I ...it depends on what the cases is there's a wide range of people that they are very religious and cultural people, so obviously I would ask them.

A: do you go to the particular matching one of the case for those people?

JOSE: yar

A: I think that has mean that we have come to the end of our interview and thank you very much for your time.

JOSE: ok.

Appendix 5 c: Transcribed interview with Siya

A: ok, right thanks again very much for being brave and participate in in this study in my interview. As you can see I am recording the interview umm just for myself to be able to transcribe it accurately. You can be assured that this is confidential and that I will be the only one listening to it to transcribe it towards my research process and that umm... yar I will be checking with you whatever quotes I have used in my final findings before it goes out to... Check that you feel that you are not misinterpreted or whether you comfortable or not umm that quote of yours being used. So umm as we know that this study focus on how OT decides about their clients' occupational spiritual occupational engagement, to look at deciding whether that engagement is... ok so yar it's this study, as we know this study focuses on how OT decides on when their clients engage in occupations that look like they are of spiritual natured in whatever we may describe spirituality is umm... How OT, that OT decides that this is a health seeking behaviour or this is part of the client's mental illness. Umm... so I want to begin by asking you what do you... what is spirituality for you in a nutshell, for yourself, for the ward and the clients here?

SIYA: ... umm for myself, spirituality really is about an innate sense of umm.. of meaning and having an innate sense of meaning and purpose. For me it is connected to God umm but not in a way that I believe is dogmatic or too much ritualistic or too looking down on others. So internal meaning and it's an internal sense of purpose that I gain from ... from my sense of being, who I am and how I am in the world and how I am with others and umm... ... and yar that's for myself personally and the values that I hold, all part of how I see myself as a spiritual being. Umm, ... I think a lot of that is influenced by .. no influenced by ... by a sense of striving to be better, to be better in not what one does but how one is. Umm in the world and wanting to understand more, and implement things into my life and I enjoy that striving myself and I also think that is spiritual.

A: And for this particularly particular ward you work at?

SIYA: umm if I think of our client population that we particular working with that we have particularly gone through that I think with challenging life histories I think that I have worked with and I haven't worked in forensics. These clients really present with umm... ... traumatic and horrific life histories.

A: difficult life circumstances?

SIYA: very very difficult life circumstances from the time they were young and still to now and a lot of that had an entrance in the way that their personality are affected and certain behaviour patterns are entrenched. Umm and really difficult to shift but I think a lot of our clients come in with a sense of willingness to change and to look at themselves and be open and honest. Some, many don't talk but you can say a 50% of them. [If I] look at our patient population now, there is some really motivated people who really want to be here and it's like for them to be. If I look now at the population now and what my

guess is what spirituality might be to them, I think it is just a movement in a sense to .. to wanting to progress with your life and look at your life and be able to look at it with newer eyes.

A: So spirituality as a motivating force?

SIYA: Yes a motivating force and a sense of of of wanting to move forward in your life and wanting to set goals going towards being more well and healthy and I think.. for me that's spirituality.

A: so that's your view on in relation to the clients here and the staff beyond the OT in this team what are they like?

SIYA: I think a lot of the nursing staff are... quite religious that's ... and that's how they.. that forms a big part of how they are spiritual. Umm... but for me, umm.. yar.. a sense of goodness is important that's comes out in every human being that umm..... and I think for the staff also if you have a sense of everybody's trying to work together for the greater good and that's spiritual too.

A: working towards a sense of greater good, ok...

SIYA: Yar, putting the clients first and umm we do here for our clients and we are here because of them, otherwise we won't have a job.

A: so there is a lot of connection to higher being amongst the staff and you describe mainly...?

SIYA: amongst the staff umm.. not.. mainly the nurses. The other people I don't know, I can't say for sure. I don't know [A: you not sure about the other ..?] I spend most of my time with the nurses so them of course.

A: so you describe spirituality as something to do with meaning and to.. it's.. almost to do with motivating for someone to... carry on with their lives given the context of their lives, u said, a lot of the clients here have gone through rather tough life circumstances. umm so spirituality is as a sense of finding meaning to continue. umm in that sense and umm you talked about, u.. before we started the interview we were already talking about spirituality and how do you see it and things like that. You also mentioned hope, how is hope linking with ... people you see here?

SAI: I think hope is is certainly a driving force for any human being towards other things. Umm towards just living well and driving towards other things. I would have hoped that them being here for six weeks in general give them a sense of hope, that's for me spiritual [and] I am not sure if it's spiritual for them. You can have a sense of having something to work towards. It's wonderful u know something to push you and pull you to changing your life.

A: and if we move a little bit towards spirituality and occupations, umm what do you, what in your view would like a spiritual occupation to you.. that is occupation that has something to do with spirituality? [SIYA: here in the ward or anywhere anywhere?]. Umm we can start in general and then we can move closer to the wards.

SIYA: I think if it's a positive.. but then I am not.. I am not sure if I am judgmental or not (laughter) but if it's a positive activity... a positive activity that is umm a human occupation that feels just right inside of yourself that something that gives you meaning... and it may or may not be connected to other people. And it may.. yar, so it may or may not be in the process be connected to other people [and if] what you do doesn't entrench on the life of others.

A: so it's kind of occupations that has a self enhancing element ...? [SIYA: yes]. But and that this kind of ...these ... such occupations can be done, like you said, on your own or maybe with other people if it's with other people. Can you give me some examples maybe umm... on what would fit those..?

SIYA: well there it can be anything. It's anything that gives you meaning and joy and meaning endeavour. That can be anything. [A: now in the ward?] In the ward, (long silence) umm I can only speak about.. I don't get involved with anything whatever else besides life skills the groups. I don't do the psychotherapy groups. [A: there's very confined structured role of the OT that had to do a lot with the cognitive practical skills of living]. Yar yar it's so small. I only see them here so that's what I can only speak about ?active. And umm, I mean if you see someone becoming aware of something for the first time and they say... 'I have never done this before I have never, it's the first time that that's I realize that's is part of who I am or I am like that' and you see their eyes open wide and they umm.. yar that ☺ for me is spiritual and I am sure they get it from other occupations here too but that's the way how I notice which is why I enjoy the clinical work so much because they umm... or they tell you directly, like 'this is really helping me and I feel like...' and they would say that and I think it's spiritual to them because they are moving ahead in their life.

A: Yar, it meant something, it served a particular purpose... [SIYA: it served a purpose, yar.] when they said that I really enjoyed this and they really found it helpful. And you mentioned obviously that is what you see because that's your interactional context with them. Umm, and you said that there might have been other occupation that they might have gotten it from in the ward, what do you suspect those might be, what kind of...?

SIYA: I think umm the comrade they develop amongst themselves, the sense of learning together is very evidenced [but] something it isn't really evidenced. But in a particular group we have now, I think that can be regarded as spiritual for them the fact that they are with other people who understand them maybe similar to them in behaviour styles or life history, place where they can feel at home amongst people. I think that would be.. very enhancing for them. Umm being connected to [A: one another?] one another yar.. I think the individual work that we do and in psychotherapy too that's important. Some people they say it's such a big challenge such a big thing that they face and they... [A: what's the big thing?] It's a very very daunting kind of group to go in. [A: yes, it's very deep you have to..]. No as deep, in a group they can't go very deep. [A: in the psychotherapy group?]. It's more interpersonally how I am interpersonally but you having to look at yourself in a very honest way and umm in that group umm and where as life skills you can still dug and dive a little bit and or there you have to be.. it's all thinking but the other one you come with a purpose to the group, you come with something that you feel it's a life challenge you don't know how it's going to go. In some ways, in life skills, the activity of the group... and because I like everybody to share umm..., they can hide behind that sometimes.

A: how big is the group?

SIYA: the group's about .. the life skills is very big, like 12 people [A: everybody (in the ward) comes?]. In psychotherapy group it's most 6. So, you are more still, it's not as easy [A: yar it's not as easy to hide amongst so many people]. Yes, you have to come with something so they stress a lot about that group. But they also report that it's a great group to go to and they learn a lot and some people say it's the biggest thing for them mostly. So those are the two big groups, the others are very soft and mild not so significant. Sort of weekly planning and feedback, like the education. [A: those don't require you to get in touch with yourself or other people?] Yes, it's more light and about living well together with other people in here u know. So I don't know, from an outsider; I don't think that's so significant.

A: you also talked about u know people needing stability, that type of people that comes into this particular ward is people who needs help with trying to become more stable whether it's through setting a boundary for themselves in or in the way they interact with people or it's the way that the ward providing that stability through the contract and the rules within this ward... umm, and you say spirituality has to do with meaning and motivation, do you see, in your view, is there any link between spirituality and providing that stability?

SIYA: Yes, I think there are some ways there are certainly. I think most people need to have structure and stability but for them they haven't had it. I mean I know it's generalizing that they haven't had it before or they so destructive breaking down by themselves so umm... to be in a contained space where you actually feel safe from yourself and others I think it's very important to build this structure to hold another things. So I think it's important... focus.

A: And umm.. are there any people you worked with recently or before where umm occupation of different kind had helped particularly to set up this stability that had contribute towards the stability issue that seems quite important here?

SIYA: [are we] talking about them in the wards here or after they go home or...? Cos' we don't really know what happens after yar... [maybe let's focus on the ward then]. (long long thinking). Yar I can think of a woman who's nursing sister. She had living in the States... that come here to look after her father. Then things fell apart umm she suffers from bipolar so very high function and always psychiatrically trained. Also psychiatrically trained. [A: sure, there's quite a combination]. Yes, I know.

A: when you are.. not only medically trained, you are also psychiatrically trained and you have a psychiatric illness...

SAI: she came back because the father was dying or something. [A: and she became uncontained?] And then her father died and she became uncontained, she came back and she came here because she wasn't quite ready to go ... She was still caring for her mother, she couldn't go back to the States but she had plan to go back. But her husband also divorced her then. [A: so around the same time?]. Just sort of a little while before she come back in for the father and umm yar. ?she was difficult, she was extremely restless umm ..

A: so how did you and how did the team work with her from that very uncontained stage tht she came in.

SAI: (Long silence....). It's not ... they all get treated the same, they go straight into the program. She wasn't given any actual instructions or... Sometime they became so uncontained then they need to be called in. What happened yesterday, yesterday we had to call somebody in because too out of control. [A: what do you mean by out of control?]. She was loud and aggressive and umm... [A: did she come in manic?] She didn't really come in manic and she came into [here] quite willing to [A: or PTSD even through no background?] She came in major depression and aggressive harm to self and she came in and started wanted to be permanently aggressive here and very loud uncontained. [A: in this ward?] in this ward so we said we going to have to call her in, in fact...[A: call her in as in calling her into the ward round?] to be spoken to that you cannot have this kind of behaviour in the ward too disruptive to everybody else.

A: do you guys see everybody in the ward round?

SIYA: yes we see everyone cos' we can but you can't yar.. we can so in 2 weeks they get seen and then they can get seen again umm if necessary if something is worrying.

A: so what did the team tell her you can't carry on this way [KRIS: I don't think we carried on...]?

SIYA: hahaha oh this particular woman, umm... .. I wasn't, in fact they I think it hasn't happened yet. Yesterday there was a report to call her into the ward round. [A: it's a current person here?] It's a current person through they been very straight? With her [that] this whaling she whales, she just cries uncontrollable, she's loud, she overreacts to certain things she may hear in the group and she runs out.

A: [she] sounds very sensitive to feedback?

SIYA: from others maybe, but I think she may also be open to [what] another want to.. may say to current puts on.. [A: why do you think she's so loud, is it because she's attention seeking?] She's attention seeking and it's been a lifelong pattern so maybe all she has. She's the one that abuse her boyfriend and her husband.

A: and the first husband left her and she currently have a boyfriend?

SIYA: [yes] and she currently has a boyfriend.

A: I am just thinking u know, just attention seeking is it... I mean how long has the father passed away?

SIYA: no no this is a current patient, the other one with the father's passed away left a few months ago. I was just trying to say... No, we didn't call her into the group we didn't call this one into the group. But that's why I am trying to think how she's treated differently... I think she's ... very restless and fidgety and she. But not disruptive to others. In the group she couldn't focus on the group easily. Umm her understanding of stuff was all over the show in the beginning. But as she went on she was... she came along and became more contained, more focused; she said that the life skills group was for her very fantastic. She said she learnt so much in this group and she's very complimentary of the groups umm but I am trying to thinking hahaha how directly how directly I can say that life skills played a role in it I am not sure how big a role[did it play] maybe other groups also [did].

A: and was she one of your cases?

SIYA: no.. [A: she was somebody else's? and if we... I know you worked here before another part of the admission in this hospital before, we focused on I think spirituality as something positive in this part of the discussion we just had now. Are there times u think maybe these spiritual occupations the clients you were working with [were] part of their illnesses was actually not particularly contributing to their health and what they are doing?]

SIYA: I think umm I am not sure what comes first umm.. but there were times report came in and report that the patients are very religious I am not sure what the meaning of the word is but it sounds like they become so obsessed with it, their religious practice that affects their social and occupational functioning. Umm... but I think it's because they are breaking down and become ill that they doing that. Also they come down it's because they are so ill they don't know what they are doing.

A: Also needs something to hold onto for stability...?

SIYA: yes, they become so fixed that that's a negative. I don't think the patient or the activity itself is negative [A: but perhaps maybe not particularly health contributing as we .. what's happening? What else] Because they already becoming ill, so they can't see right from wrong they can't see another.[A: not that the occupation itself is bad as much but it's .. they are in ill stage...?]. No the occupation itself.

SIYA: well I can think of two cases where clients'..., one is here in the ward at the moment. Client had resorted to go to sangoma for help [A: Ok, that's interesting]. And the [other] one was a woman in ward 3 and wanted help with her boyfriend, she's had some problem with the boyfriend. And this guy actually raped her. [A: the so called sangoma?], raped her and when she came in, she had already had her child from [A: so she felt pregnant from the rape] she felt pregnant from the rape and that she was so ill that she didn't even remember whether it happened or not. She remembers going to the sangoma she think he raped her but she was also wasn't sure. She was a white woman and the sangoma was a black man and she had a coloured child. [A: it's very interesting that she chose to go to the African well the local traditional medicine]. She then gave birth to a coloured child so she thought then it probably was true. But even like a few months [later] when she came in she umm... still spoke about all these things, dream like quality of the experience and the guy here at the moment was going through in his life some stress with his wife, and work was very stressful...Went to.. umm and then went to a sangoma also to seek help and the sangoma robbed him of R400000 [A: ouch, it's a lot of money]. Sangoma was like very attentive and listening and seemed very kind and then said to him that he must quit his job cos' the job is too stressful. [A: he must quit his job?] Yes, quit his job. [A: what does he do?] He was a lecturer at a college in Cape Town. He has to left his job cos' it is too stressful and after a few weeks he asked him to draw on his pension [A: draw his pension after quitting?...] after quitting his job the money in his pension fund and must bring the money to him and he describes as he was in such a stage that he was so vulnerable that he just did it.

A: I think this is.. the two cases you are mentioning now are rather interesting. [SIYA: because it's more like abuse]. Because we are having someone with a mental health.. mental illness background who are vulnerable and in their way maybe becoming ill at the time and more vulnerable and went to seek help. And went to seek help at some of what we regard as spiritual leaders spiritual healers' help from the sangomas of which in two cases had unfortunately gone horribly wrong. The one got rape and the other one lost a lot of money. I just want to go back into each of those in more detail, just to umm get a better picture of those two people umm maybe let's start with the lady first. So you described her as a white lady [SIYA: White lady young..] how young?

SIYA: twenties [A: did she come through female and then here?] that I was not sure cos then I met her in ward 3 she also was referred to this ward here while I was in this ward. She had been here before. [A: how long ago was that? I just want to picture the context] This was about three years ago she was in w3.

A: oh so you were actually in w3 not so long ago. So you probably changed when Wendy* left?

SIYA: No no when Wendy* left I came four months after she left. Cos' she left and then there was somebody standing in here Sue*. And when Sue* I was here I was at [name of a workplace]*. And I came back and Sue* left. Sue* was here for four months.

A: oh yes now I remember, ok so you actually only changed to W1 recently. Well as recently as I had been working here in this hospital. [SIYA: yes yes]. Ok so the lady is a twenty odd year old, white lady, did she ever explained how she went to the traditional healer? One's normal assumption is that she would go to the Western GP u know, context.

SIYA: yar yar. I think she could have gone that route there was a element of umm... ... if I remember correctly, she matriculated but there was an issue of insight or intelligence. Maybe there was mild ID cos' I can't remember whether or not she matriculated. [A: did she go to a special school or mainstream?] umm..... I can't remember that.

A: just tell me a little bit about her, u know, the picture of her.

SIYA: She was from Thailand she was an adopted child, only child, the only adopted child. Mother was tired of this daughter cos' the mother she was also bordering on depression herself [with the client.] So the client would be really easy on her boyfriends and she would do anything her boyfriend would say to her and [in] abusive relationships with her boyfriend and she went to study as well also [and] went to do some care, nail care [A: oh like a beauty therapy?] like a beauty kind of thing therapy but was never

successful trying to set up little business at home. She was never very successful, she never became self sufficient and depends on the mother quite abusive towards her mother.

A: she umm... I am quite interested in her I mean.. she defies a lot of the normal societal assumption about I mean..one would have expected okay she was white she would have probably gone for Western medicine instead she did something what a lot of people wouldn't expect. And also her gender relationships, one usually would expect it's the woman are in the victim role and not in the perpetrator role. She.. okay, she went.. did she go to a GP do you know if she went to seek help?

SIYA: I am not sure if it was psychological help she seeks. She may have been a patient here before then before she went to sangoma. I think that could have been quite possible. Because she lives so close to here, she lives in [a suburb close to the hospital]* it is highly likely that she was already a patient here.

A: so how did she find the sangoma, did she ever tell you?

SIYA: umm I think she started moving around. And young I think when people are young there are more integration younger in the sense she's young now. If you had been black or young 20 years ago, you probably wouldn't been going to a sangoma. [A: you mean our historical context?] yes, and I think she was involved with the Rastafarians... that kind of crowd and or who were drug people and I think that's the way she got hold of a sangoma. But then yar a lot of abuse of the boy [A: did she abuse the boyfriend or the boyfriend abuse..] [she] was very soft and fragile [A: oh ok so I was wrong, cos' I thought she was the one that abused.. she's the victim?] no no no. she the victim of the abuse, she went to a sangoma to help her with her boyfriends. Ask [him] to tell her in terms of relationships with him and then the sangoma said to her she needed to do this, needed to have sex with her to cleanse her. Something like this. [A: And she,] ... she didn't really resist she became dissociated with this afterwards that it never happened.

A: almost like that she tucked it away cos' you mentioned that she had these dream...

SIYA: she would say I wasn't sure if that actually happened but then I had a child and the child was coloured umm... and then it probably did happened she said. And that was a shocking story.

A: so actually the team wasn't sure if it happened or not.

SIYA: I think the mother reported it and gave collateral [A: that it actually happened?]. But there was no court case or charge laid against him. Terrible story.

A: and.. did she ever became uncontained about it.. I mean when asked about did it happened? And the mom then obviously...

SIYA: no then the mom have to then look after this grandchild that she just can't... couldn't do it herself.

A: and so you were at female admission then and in terms of your... the general OT process with her? Did she never come into any of your groups?

SIYA: Yes she came to many of my groups and I can't remember... I did see her for something; what was that... I think it was work thing see if I could assist her of getting involved in some work program. [a: yar she had matric...] and she lived nearby. And then I did see he [A: very difficult, oh ok...]. r but like then she was like not motivated at all... she was not motivated at all to come but I know engaging with her therapeutically was very difficult. Yar she was very difficult to move. [A: why was it difficult, in your view?] such a long time ago, I say she became quite rigid in her thinking quite demanding too and stubborn. So yar if I look back now there was some ID that probably covered a lot of how she engaged. [A: do you think ok now if we looks like we are towards the spirituality aspect in her case, although one particular repeated occupation it was certainly a way she went about seek help for her health umm... and did you ever engaged her with the umm... to talk about this sangoma issue or...?] I don't think there was ever a engage in that, that we understood it better.. no not at all we just touched on it in the history. [A: and now thinking back, would you have do you think you would have wanted to get more into that aspect of her story with her?] umm... I think the fact that she was so difficult, cos' I know she was referred to W1 here and the team felt they know her, she's been here before this is not workable for her. It's not going to work and sometimes it's also a desperate measure they don't know what to do with her, let's try something let's try ward 1. [hahaha] and she been here and everybody felt no she's been here been through the program no it didn't work for her. She was unwilling to engage or couldn't engage or to regress ...

A: do you think that would be part of the barrier why you didn't go into speaking to her about this incidence of seeking help which ...?

SIYA: umm it would be a barrier, but I also think that work time pressure is a barrier to investigate there and here...And here we have a little bit more time to understand that better but at admission there's definitely no time.

A: now let's talk about the guy, [SIYA: who's the guy?] the current guy, just describe him a little bit for me in terms of how old he is and what background...?

SIYA: he is umm 43, he was a carpenter initially and then umm... and then again like very well qualified carpenter and then I think did some teaching diploma teach at umm.. lecture at umm one of the campus in Cape Town. [A: is it a technical school technical college?] yes technical school I am not sure what subject he's teaching. [A: sure, that's quite a lot of progress]. Yar, but somebody is..well he describes himself ... umm trying to get a handle in this guy in actual fact. He is umm... he was first seen in Vanguard clinic and there they think he was malingering. That he own all these money to people and all these stuff is a lie [A: Is he bipolar as well?]. Not bipolar, a lot of amnesic disorder, he forgot everything about this. [A: psychiatrically, what's the diagnosis for him?] Psychiatrically, umm narcissistic personality disorder and came in with depression [A: that's after he had gone and given all his money away?]. All the agreement money whatever, but he was feeling very down before that which initiated this visit to the sangoma according to him.

A: so was he a previous patient here before [SIYA: no]... or was he a outside referral

SIYA: he was seen at Vanguard clinic referred from the community. There they thought he was malingering was probably trying to get out. [A: but he's suicidal? Did he come through my system?] He was suicidal, no he came straight from Vanguard. Sometimes they come straight from community from outside. [A: oh from outside, cos' I was thinking to myself, hang on I don't think I know this person before and if he was current I should know him]. No no they thought he was malingering that like he owe all these money and he is trying to get out. They still have to refer him here because he was suicidal last time [from] one of the clinics.

A: So he's 43, depressed suicidal came in after having done...

SIYA: losing all these money, he claims after he lost all this money he had a blank period of about a month. [A: blank period?] He doesn't remember anything after this, after giving the money away. Just and found him somewhere in Kalkstad somewhere in Gauteng, somewhere he sort of just found himself there he doesn't even know how he got there. And then umm he sort of came through he phoned his aunt and aunt went all the way up to fetch him.

A: and he hasn't had any admissions to here before? Or anywhere? This is the first time?

SIYA: no, not anywhere the first time. [A: is there any traumatic event happening in his life?] Yar he's got lots of trouble in his live his wife. He feel inadequate to her cos' she's a weight lifter and he's like a thin guy and she's not in just any weight lifter, she a champion just came back from a common wealth game or something. So umm he feel very insecure with and around her I think they... and it's the 2nd marriage and the marriage is breaking down [A: second time around?] so that the first marriage also broke down.

He describe himself as a... it sounds like a very inadequate dependent person he umm.. always look for others to emotional yar and give him guidance. He has never been truly himself and would stand up for himself and would like be confident and umm... and that's why he is extremely vulnerable and we believed his story. We said it's true [A: because from the picture?] because from the picture you can get the sense and idea. But that's the terrible trauma of him losing all this money. [A: So that's [reason] for the amnesia not a head injury or something else?]. No no no.

A: so how are you working with him?

SIYA: As he is standing here now is like he's quite narcissistic like to teach and lecture others giving advice to others, not looking at himself. [kind of dugging and diving?] no no not in a way but that he is so verbal but one does not know what he's saying. [A: ok he like to advice others he like to more look external and don't like looking in]. So, for myself I see him in life skills and I will point out a certain things out to him. So we may say you speak in a very confident manner how does that it doesn't quite match umm the personality the avoidant dependent person you speak about.

A: so it almost sounds like maybe he's not dependent like he describe...it may be something else?

SIYA: it's all within today now.. [but if he's so confident..] he's confident in the way he speaks... u know strong voice.., but that I think that the interior is quite fragile soft and... [A: the rigidity is the shell?] yar the shell [A: the fragileness within?] inside yar.. so yar.. so his case manager key worker would also point this out to him because the whole focus of this ward is despite what had happened to me what is happening to me who am I interpersonally how do I interact with others. What's the problem there are, how do I deal with it. So umm that would be the focus individually and I think there has been progress a week two weeks, he's less... he's more able to reflect more and he started remember stuff more and more. [A: of the period]. Of that month that he blanked out or something.

A: and umm... we spoke of spirituality as meaning and motivation as hope in terms of him, do you see any spirituality in his case?

SIYA: Not one, he said that he said it's... he really feels this is the first time he's able to speak about these things inadequacy inside himself, always the person umm.. does good for others that he can yar always please other people and be in their good books.

A: is that true through or is this what he says?

SIYA: we don't know but the wife actually need to confirm this, I think we had contact from his wife. I must really confirm this and umm.. yar.. so yar so he said it that the groups are really helping him. No necessarily something I would say. To focus on himself his thing his life, how things had gone wrong what he needs to do and set goals for himself. But I am sure that a lot of this are done in individual work and with the psychologist.

A: and the three clients you managing now, are there?

SIYA: the one umm she's dependent personality, she's.. this is her final last week. And I feel very demoralized [A: u feel very demoralized?]. having worked with her, she's so dependent, she had a life history of 29 years of emotional abuse by her husband who's a serial womanizer and gambler and... [A: She's married to him...?] she's been married to him for 29 years and he's done that to her since the beginning [A: wow] from the marriage. She just never there [A: do you think that's has something to do with her dependent ... so she couldn't?] So she couldn't, so [I] have been just a labour trying to case manage her. She does have accommodation outside with her sons but she doesn't want to go there. She also got a very nagging style and she knows or she assumes that she's going to damage his marriage further living with them. So they live in a two bedroom flat outside of their in laws ' house and that's the only accommodation for her. She can't go back to the husband cos' her husband's there and they are not divorced yet. The husband had started the process [A: the husband started it..?] , she can't face him right now. They both realized this is pointless [A: that it's not working?]. umm so he's said that they are going to speak about it and he was going to get forms she's going to have to fill it in. She's also seen our social worker about it about the legal process to her about it.

A: do you think she's strong and...?

SIYA: well I thought that she had made a certain gain because she's been able to look at what's her behaviour. And something in life you must accept, u know; you can't expect to go from here to an old age home. She's only 40, no he's is 53, but she's someone who's decided herself as a old woman. She's an old woman, no life goals; the only life goal is to go to an old age home like she's here. She's very contained in the hospital because there are other people around her and there are people care for her and so on. While she's quite independent and see to herself, she can cook and clean but she umm had decided what to do – being old and going to the old age home. And her son must come and see her like weekly [A: is this why you feel demoralized?] No, no solely. It's slowly moving her to see that the son wanted her to come home. And the sons now see this is how it must be if I want to make success out of this u know.. why don't I get along with the daughter in law? Wanting her to look at things in the daughter in law's point of view. Umm, umm daughter in law's point of view. So I thought we made slow progress... slowly but surely she's making progress, she goes home for the weekend, and somebody may have said one thing or does something like a daughter in law goes away for the morning and then a whole weekend was spoiled because the daughter in law doesn't want to be near her and how can the daughter in law doesn't speak to her and so how can she live in the same house with this daughter in law.

A: is she quite high EE?

SIYA: not really high EE she's really quiet and.. but she's very over-inclusive. When you speak to her, she.. [A: started expanding and expanding?] And yesterday I had debrief... now this is my client now... So yesterday she comes back from the weekend saying she wants to kill herself so the doctor does an assessment and said very well she has threaten to kill herself before for attention so she probably would kill herself. Then I hear today that she's sitting and talking to the nursing sisters all this is case management. I hear that in the afternoon there by the doctor this afternoon who said that this case had been mismanage by me because this whole thing about accommodation should have been sorted out a long time ago. [A: the accommodation?] the accommodation with the son. [A: I see why you say you need to be a bit of a social worker and a bit of a..]. So I did some work around her and her interpersonal around the accommodation that was what the focus on what we do. She's seen the social worker and fill in some forms. But now they look at me and I mismanage this patient. This is the first I hear of this and nobody had said anything before [A: one week left?] She's leaving on Friday but the woman herself two weeks ago said he wants to be her out of the hospital she's dependent he can't take these dependent people and they draining the system. She must go home and kill herself that's what she must do. Now today he says I am mismanaging this case. [A: now she's suicidal?] ha you know I was the one that sorted so that she would stay and try to get family to pitch up for the meeting. So that's beside the point for me... that's beside the point... what I am actually trying to say is that... that's demoralizing, if you work with someone for six weeks and the last week they move right back to where they were. [A: and personality is not easy to change?]. Personality is not easy to change especially not in her case hahaha

Appendix 5 d: Transcribed interview with Sai

A: Let's move a little closer into the range. Ok, first of all thank you again for being willing to participate in the study as you can see I am recording the interview umm cos' I need to transcribe it. You can be reassured that this is confidential so I will be the only person listening to the recording for transcribe, get it to put it down to word format and so like we said earlier on like when I met you guys last time my study focus on how OT decide about their clients' spiritual occupational engagement through a clinical reasoning process whether it is a health seeking behaviour or part of their illness. Before we get into the cases, can I ask you to begin by telling me what spirituality is in your view in your mind?

SAI: Spirituality is a very fine line between being spiritual or religiose I do think through it is important umm in OT because it makes up.. it just part of making a person whole u know as the person as being holistic we do look at that aspect of it. And I think with spirituality it's your belief system it's connection with what you believe in and I think we need respect for that even though we dealing with psychotic clients here, we still need to consider that that is still part of that person's life so yar I would say in a nutshell that it's important and that it's the belief system of the person that guides them.

A: so it's belief system and umm... where would these belief system be coming from?

SAI: I think it's... it could be like cos' we belong ... it 's difficult cos' we belong to different denomination but it's more like Christianity who you believe in and.. the power you believe in and here it's difficult to make that fine line because of they are religious and that religious is around their psychotic-ness and yet there is a spirituality.

A: So there is something spiritual something going on there?

SAI: yes yes

A: ok you are talking about spirituality as a connection to a higher being may it be God or may it be whoever you see the higher being is. Umm ... ok, yar that's fine and having said that is spirituality, have you been in situations where you had to.. u know, work with clients and the process you had to decide on their spirituality occupation and their engagement of occupation that have something to do with their spiritual expressions, is that part of seeking health or is that part of the illness?

SAI: Man, that's a very interesting question. I just thinking now we had a client, he was here about say seven eight months ago. And also 17 year old boy and ... what stood out for me was that he was still

deciding that whether he was gay or whether he was straight. And often in OT groups when we had groups, the talks he would have are always around u know, like the Bible, parents' beliefs and how it's wrong and that... So, obviously the group, I always had to umm.. tell him that the focus of the group for now or the focus for 45 minutes or this hour that the focus now is maybe to complete tasks and maybe afterwards we can talk about it. So it was quite difficult for him I think because he went through this stressor, u know when to talk about it because he was trying to find out. So we do at the stage in the ward we allowed him to have his Bible.. so we did allow him to have that space that he needed. Because I think yes he was here for a reason because he broke down, he relapsed, he was sick, but also at that time he needed to know in terms of who am I and that relig-, spirituality in his house is important as his parents now have difficulty accepting him as a gay person. So I think that I don't think that it was linked to psychosis solely, I also think that because of his spirituality and then he umm he knew that the Bible was a guideline for him and he started questioning, u know.. like for example, the 10 commandments say you are not supposed to and so he's questioning so why am I? and that's difficult cos' you don't want to... it's difficult to impose on another family's religion and their belief and the way they are doing things.

A: so you were saying that in his case, he ...so do you think he had the break down first or was the break down in relation to him now having to decide ok now am I gay am I straight?

SAI: I can't really say because.. because when he was here in the ward it became an issue. So I don't think it was discussed or maybe not allowed and now when he was here, it gave him more time and you know you got a lot of time to think cos' he got well umm it was in a stage where we wouldn't acutely psychotic unit. So we did rehab things and he got well and then he started questioning this so I think it was mainly in relation to the break down that happened it gave him more [time] but I don't think it happened before the time because there was no space and time maybe it was not allowed at home maybe it was not talk about.

A: maybe it wasn't allowed to be... to think about it now that he is in a different space than to being at home that's actually time and space and freedom to think about it. (SAI yes yes.. to think about it). Umm how did it happened, in terms of why did he break down?

SAI: the break down was mum and dad. I think dad had an affair then mum couldn't handle it and the social stresses was for him too much cos' they were a close knit family and then suddenly this happened. I think then he also started questioning his role and where does he fit in and that maybe it's because of him. Because it wasn't his first episode when he came. So it happened before, so maybe it's him u know.. I think that's why he relapsed.

A: oh so maybe I think I am to blame? (SAI: to blame for what happened yes yes) for their marital problems? (SAI: yes)... Umm in terms of diagnosis, what was he?

SAI: he was bipolar bipolar umm and he was not substance abuse. Cos' often we would have (A: more of a mix?)

SAI: yar yar...

A: was he on a down phase then?

SAI: men it was up and down ... it was up and down, there were stages when he was manic and there are stages when u know, he would put on music (A: it's very quick?) Yes, like you would just have to watch his mood every time.

A: Just now you mentioned you say it that you didn't think it was so much part of the illness that this was something... possibly more tending towards more actually a healthy behaviour engagement.. looking into the Bible that he was doing, how did you know? What kind of things pointed you to think that this is more towards the health?

SAI: You know, I think when u when we in groups, and we know about the.. the symptoms whether it is positive or negative symptoms of the illness [and] we tend to look for that. But in the groups, he was able to engage, he was able to ... follow instructions, he was able to engage in the activity, able to complete tasks [and] concentration was good. There was no time I could really observe him being psychotic you know maybe talking to himself laughing inappropriately. (A: There's no positive symptoms coming out?) Yar yar, he was able to hold the conversation with you, appropriate to the topic and things like that so I do think that for me when he was more settled, that.. I don't think it was linked to his illness because yes his illness was there but he has settled. He was on medication, he was engaging different therapy. He went to psychology, he went for physio, seen the social worker and then other groups besides OTs, [he's got] quite a multidisciplinary team getting treatment. And I think he got better so that's why I would say because observing him in drumming is now different to OT [and] same thing would come up.

A: So this was a consistent issue?

SAI: It was consistent. Yar.

A: Now you also said that, you know, he was allowed to have his Bible and read it u know... try to.. cos' that's seems to be the way that he's trying to get answers towards the question that he was asking about his own sexual orientation. Umm is it usually not allowed?

SAI: Men, I would say not usually not allowed, just part of the ward rules that [when one] just come in, like music centre, whether it's a Bible or book it must be handed in. (A: Yar, cos possessions had to be handed in?) Yar, but they do have time.. like.. um we would just, I would just let him engage in activities and maybe three o'clock they have snack time say Shane* (not real name of patient) half past three until four you are allowed now to have your own free time do whatever that is what you want to do. Because he was quite able to control that time and was able to take the half an hour to u know use it without you havin to tell him now okay...

A: so does he always chooses to go and read his Bible for the half an hour or does he choose to...?

SAI: Sometimes [he would] listen to music umm.. it wasn't only about the Bible umm sometimes he had articles that he would read. I think at this stage his parents gave him some other book. Also not to do with the Bible but I think also not to do with spirituality but some positive, u know, positive book about.. (A: motivational?) motivational type of thing and he was into reading it.

A: and out of all the different range of things he did in that free time umm which one of those looked like a spiritual occupation to you?

SAI: I think the reading... mostly stood out for me because I think the music was more.. it wasn't too Christian music or whatever but the reading stood out for me because it was always around ..when he came back the next day he would tell you that I read this and this is what I think it meant to him. So it's always around the Bible or this positive book whether it's about motivation or what. U know it was always around that. And you know come to think of it, he at the stage he said umm.. that because we umm notice he being different with the boys and we could address it with him. And he said that but he's confused but this is how he feels .. so we didn't allow relationships or anything but we still allowed him .. to ... I think he was.. I think we still allowed him to be open about it and we were open to talk about it maybe because we more educated I don't know maybe because we not part of his life at home when it comes to structure, the rules and regulations but here it's different and I think that was important because it was so him being him u know and (A: he's confused at that stage?) Yar.

A: And by the time he walked out did he decide or...?

SAI: By the time.. umm by the time he leave, he was.. I think he has decided to an extent but he went onto LAU. And it still went on. (A: from here?) Yar from here. It still went on at LAU, but at that time I didn't work at LAU at the time I didn't follow him up but family intervention has now happened. Dad and mum came in for sessions (For themselves?) For themselves, how to deal..handle him? So I don't know what happened, I know that in LAU he also stayed a long time before he was discharge. (A: how

long did he stay here and how long did he stay at LAU?) He was here yar.. He was here for about 3 months max I would say and then say 6 weeks because there is a period because he is stable and so just engaging in activities so they just basically had to sort out placement when he goes home (A: When he's at LAU?) Yes.

A: And that's regarded as long in terms staying? What is the average length of stay people stay here? (SAI made a sigh of difficulty in answering/amazement)

SAI: Oh it's long, the longest we have 6-7 months it's long.

A: Usually are we looking at about 3 months? [SAI: usually]. From here to LAU the whole thing?

SAI: Yar, from here to LAU now is quicker cos' our turnover rate is faster now (A: because of the pressure or...?) because of the pressure and according to the doctors it's just the plan now is that they must be apsychotic and they move on. There is no real time now here to do a lot of work so like I said they just engaging in basic activities but at LAU the period is now longer. So previously the role are reverse. (a: oh I see, so this is just to recover and stabilize and then they move on?) Recover stabiles and move on so at the LAU you would stay x amount of time in order for you to settle and engage with groups.

A: Are there set 4 weeks [or] 8 weeks program that are at LAU?

SAI: No. at LAU it's not a set program but they got a day... a day.. DPU (day patient program) unit. So that's the set program for 4 weeks so if you are in this program for 4 weeks you need to be discharge at the end of the four weeks.

A: does people get discharge from the LAU go to the day program? (SAI: yar). So it's a bit like a outpatient a bit of follow up? (SAI: Yar). What 's included in the day program?

SAI: men I... I am not sure but I think they do a lot around the life skills same like I do at LAU. (A: Who runs these?) The person who runs it, the coordinator is a psychologist but it is mainly the OTs that work there so the OT run the program in terms of all the different activities.

A: ok, now you said he stayed here for quite awhile and from more the beginning, was there a changing point from.. no no he's definitely psychotic we can't try and engage in this umm occupation of Bible reading for example to now he's actually okay we can let him do that, was there a transition?

SAI: Yes there was, I think when he was admitted, he was really psychotic, disorganized speech, he couldn't really engage in a conversation. He would talk about blue he would talk about black and ?star that type of thing. So he need to be stabilized before he can engage in an activity so now when he was ready only then he started you know like when he was psychotic he never thought about the Bible or about reading things..

A: Oh the psychotic behaviour had nothing to do with the religion or spiritual at all? So it's only after ...

SAI: It was only after when he was all settled and taking his medication.

A: What was he like when he was psychotic, what kind of behaviour?

SAI: u know he would he would umm.... Dance men inappropriately and sing loud without consider rules or the rest of the person. Sometime he got so uncontained he would scream and you need to put him into seclusion time out. Umm or you would have a conversation with him it always it always trigger something that happened at home u know and he would speak about now and then he would get agitated and go on so you can't handle him kind of type thing. (A: and then he just keeps going on and on? U can't stop him?) You can't stop him. You can't stop him. He was never...violent u know never violent [he] got lots of feminine thing about him u know he was never violent but very psychotic you can't stop what's going on (A: perhaps rather verbal rather than physically violent?) Yes he would just sometimes just scream and shout or you know those type of things.

A: And where was this changing point between he being ill and he being well?

SAI: u know I think it was umm it could have been the input of the therapy but not really it could be the medication I don't think he had been complainant when he was at home. So yes when he started using his medication obviously it was supervised with structure to it umm Because every day you know this is going to happen today this is going to happen Monday to Friday this they get told that and this get repeated all the time and rules stays the same all the time, nothing changes. So I think the structure u know I think when he used to the structure he settled and that worked...

A: So when did you notice a change in him from that screaming loud dancing inappropriately to him now suddenly actually thinking about more about you know about life issues?

SAI: Men I think in the beginning like I said he was psychotic so I think after that psychosis had settled down then the change begin. Because was more easy to engage him now engage him in activities in the ward program. Family therapy sessions happened with him so the parents would come in... u know that was where it changed. U know when things really started changing in terms of treatment.

A: and umm, going back to allowing him to have the Bible time? Umm who initiated it who thought about that as a potential important activity for him first? Was it a team thing was it a ... you or somebody else?

SAI: I think it could be a team thing, because in OT, like I said whatever happens we take it to Cardex (ward round) and it didn't only happen there when you asked about the Bible we spoke about. It also happened in psychology also, so now also as a reward type of thing you want him to engage in activities and sort of telling him if you can.. do this then you can .. later you can have that. So that worked. You can say behavioural modification type of thing, it worked for him. So yar, I think it came out of different team members and then we just talked about it in ward rounds and we have decided as a team that okay maybe we should try this. Yar..

A: And ...

SAI: and.. sorry to .. sorry to dingise you there, the psychologist, what we have done is besides him; it came out that point in time that different members in the ward had, u know, same things about... he was questioning this spirituality and religion so we decided we would have a group, the two of us; around it. So there was space created now to talk about things that came up whether you Muslim or...

A: the group for the staff?

SAI: No, for the kids. So besides Shane* there were a couple other kids that went through ... and we were questioning because everybody saying in ward ground they grand.. they religious religious so we decided the two of us (A: who's the two of you?) it's me and the psychologist (A: so the two of you decided to do this spiritual exploring group... with everybody in the ward?) No, it was only selected few... (A: those few that had those...) yar and it was just this space, for an hour we would set up and we talk about.. u know the issue that came up and it was also time for us to reflect on our religion and we could make example of things that happened and how we deal with it. And they would come up with their things but umm yar psychologist left also resigned so it collapsed.

A: was this going to.. meant to be a slightly more regular group?

SAI: yes. It was a regular group... for about... six weeks ...

A: what did you called..., how did you actually name this..?

SAI: men, I can't remember but we when we discussed this group it was specifically around u know spirituality and about being religious so umm maybe we called it that... so...

A: Spiritual religious discussion group?

SAI: yar discussion group.

A: I am very interested in this group because this is something I really haven't heard before in other interviews. So you and the psychologist, was it because of Shane* this conversation started... how did this u know how did the need for this group got identified?

SAI: You see in that time we were still on the old way of case managing and Shane* was the psychologist's client. So a lot of groups and things that happen with me I had to discuss with her because now she's the case manager.

A: so you basically giving her feedback on what he did in your group? Ok.

SAI: yes. But besides Shane*, u know, in groups [where] you make soap for example they talk about other things. (A: yes conversation going on there). So you pick up that it's not only Shane* it's that person that person that person. And then we would ... I identified a couple of them and she also experienced some. So we sat down and we decided maybe we should give it a go maybe we would just discussion in the group and see what comes out of the group but it was all around religion. And then I asked her to facilitate the group cos' I am not so into feelings I don't know how to handle it if the group becomes emotional and things like that.

A: do you co-facilitate?

SAI: yar yar and at the point I was participating in the group, being a participant observant and afterwards we would evaluate the group. Umm but it was... you know I think it was needed the group. And it was quite emotional because umm you you it's nice to see progress cos' at that point in time the client has progress and have improved you would see a different feel of the client, it's more realistic topics that comes up.

A: So 6 weeks, you have probably run this group 6 times once a week?

SAI: yes it was once a week, so 6 times.

A: now, what was the ... I just want to start right from the beginning the thinking process. So it was... it kind of started cos' of case discussion the old ways when both you and the psychologist saw actually there are quite a few our clients struggling with a similar problem umm here... In order to identify this need.. how.. what kind of.. in your mind in the psychologist's mind, the two of you, how did you frame this problem that they have that was umm the need that needed the group's intervention? What was the kind of ..?

SAI: I think umm for me how it came about, I would say that when they now have time now to settle and into the program they now show umm ...remorse of what happened. So yes I have been prostituting and I now know it's wrong and according to the Bible it is not suppose to happen or according to my belief system, so [they] regretting what has happened. What Shane* now, I am going through these emotions and I am questioning myself. It's not only Shane* but a couple of the other kids as well the different background and scenarios. We had some that was gang raped and there was some that lived on the street and is now u know.. if I have done this that might have would have happened so umm by creating this space, it was always it always came back to regretting and how I am suppose to be..

A: so it's almost like, it sounded like almost the clients needed a space for introspection of... and they would look and evaluate what they have done umm with a particular I don't know.. moral systems? Which you mentioned as what you saw as spirituality and the two of you, as the team members, the psychologist and yourself were there to do a guided introspection with them?

SAI: yar... with the client, I also think it gave us at the end of the day when we evaluated the session, we could see where the insight is now is improving [through this], because now they are able to reflect about what happened and what's suppose to be.

A: and therefore I wouldn't do this again and I would do that?

SAI: yes yes allow them to work out their own umm... plan now so in order to not be engaging in that, so what are you going to be putting in place? And there's where the OT came in with the life skills, the goal setting and things.

A: did you see the 6 people regularly? (SAI: regularly? Yes.) So it wasn't different 6 people?

SAI: no, we saw the same 6 people. And I think we have had that discussion around that whether to have it close or open. But we realized that in the first group that so many things are coming out that is personal that we don't want to every week we just have a new person coming in. So it was more confidential type of thing, so it was the same members all the time. So whether we had the discharge in between, it remained the people that were remained and you know..

A: so if the 6th person was gone, you would rather have 5 than to have a extra person? How did you... what was the criteria [for] identifying those six people that went into the group?

SAI: I don't .. u know, now that we are having this interview, u know I don't think there was a criteria. I think we out of the members that were here, we took the members that are most stable people. People that we knew, cos' I would give her feedback from OT, nar I don't think this person would benefit. Or u know maybe yes, because we had this topic today this person was.. he could stick to the theme and be realistic those type of patient we would then take.

A: so you look at someone who is stable?

SAI: stable stable yar.. because otherwise it would mess up, it would defeat the purpose because you come here ad you are psychotic you don't know what you talking about and it disturbs the whole topic of what we discussing.

A: and so the team together sort of decide who those 6 people were?

SAI: the team don't decide [but] in cardex we would make a note when we go through different members we make a note the two of us. Afterwards we decide okay, no this person is not suitable.

A: who was.. what are the characteristics of those who were suitable besides being stable? Are there other characteristics of those people?

SAI: not really not really, you know how it came was, in OT there will be things that come up and I look out I had noticed and u know this week this was the issue in OT. And maybe we should take this now and make it a theme so we wouldn't, u know, for the six weeks, we didn't plan out like week 1 this is what we going to do and week 2... we go on a weekly basis. So in the ward, people are sexually inappropriate maybe we need to take that up now in the group so that's how we came about our themes and people that engage u know like you say, stable; it wasn't other characteristics about you had to do this and that and the other because all of them is valuable in the group, they all had, u know, insightful stories that we could work with.

A: what was the general aim of these groups?

SAI: you know it was umm.. I think in the ward at that time a lot of things went on, u know as adolescents you get different umm pathologies. And some of them they handle things differently. So there was no space for these adolescents to talk about.. you could see that umm Mary is quite stable quite with it and needs to move on now but Peter is keeping her from doing this and because of that she's an introvert and she's not talking. So where there was no other space for them to let out.

A: so it is almost a... the goal is to take the we call them in bracket higher functioning 6 of the lot that could benefit from more in depth... looking inward or looking at what's happening...

SAI: yar as an OT for me it was difficult, I spoke to Alice* about it; a lot of things are coming out in OT and I don't know how to.. [A: there almost seems to be... there needed to be another group space for these...] Yes I didn't know how to facilitate like I had this boy once that said that I was gang raped and he never mentioned it anywhere else and I didn't know what to do with this information. So I don't know how to handle that at that stage and I think that is where it came about. Because after your groups you would think about you would evaluate and see that this came out today so we need to do something about it.

A: and also I mean doing told that one of your clients been gang raped is not an issue you can just left, you have to..do something about it.

SAI: you can't because just the fact that he mentioned it, it's like I need help. I need to [Process and...?] yes yes [and be okay.] Because he had been here five six weeks and only then it came out. So it took him quite long to..to build that trust.

A: to be able to trust you to tell you these (SAI: yar). Umm you said spirituality came out from these groups, how do they feature in these groups usually?

SAI: men I think when we had, say for insistence we talked about people being sexually inappropriate now, that's the thing going on in the ward, how would you say Shane*; how would want to.. how would you handle it? What's it doing to you at the moment, u know? Umm somehow it always came back to belief systems according to the way they grew up according to there's always guidelines, it's suppose to be like this and how it's difficult for them. So we didn't take the Bible u know and did scripture which is like the way or whatever but it came from them. (A: they referred to their person?) Yes they referred to their person there

A: would you say, there was any other way that spirituality umm... was present in the group?

SAI: men I don't.. I think maybe there was ways but there was no space ...for it that we as a staff didn't look at it.

A: what way do you...referring to...?

SAI: you see in the morning it was part of program that you eat and you pray. Umm so spirituality even it's different religion but that's part of spirituality. But we didn't create a space for it like from 2-3 we going to have ... [A: prayer time] prayer time or singing time or Bible story times or whatever nothings like that.

A: so nothing structured concrete in the program but it's done in the everyday occupational engagement attached to occupational engagement. Umm when they pray is it a two minutes silence or a particular ... prayer..?

SAI: it's a particular prayer in English that everybody prays. There already ...I don't think we are discriminating but.. already we don't all pray the same thing. So, even if I am a Muslim I must pray this prayer because it's part of the ward program and whatever. There already maybe like you say that two minutes silencing is something to look at. Because then you can engage in your own way and....

A: is it an.. the praying before meal time a nursing initiative or who came up with such things?

SAI: men when I started here it was already part of the program so I do think it's nursing because at meal times it's only nursing there while they sitting to have their meal and security people.

A: is it often a Christian prayer? [SAI: yar yar]. I think that's similar to across to also other... now you also mentioned that u know although it is religion it's still part of spirituality, I am interested in your choice of words there because that's ... I mean, do you mean that perhaps there are other ways of spirituality beside religion?

SAI: besides religion, men umm... I would say yes because I got a religion and my religion because of my religion I got a different way of being spiritual. So my religion is my guide of my spiritual life and there is people that does not belong to a religion but can still be spiritual but I do think that it is two different things and you are allowed .. I wouldn't say it's wrong [that] there's a right or wrong and ..and I don't think there is umm it's it's a... it's a ... not a nice topic because we all belong to different religion but yet our spiritual well being for all of us is also different you know but for everyone it's important to respect that. So yar, I do think it's two different things.

A: Ok so there are people who are non-religious but potentially spiritual as well, umm have you had anyone like that in the ward, where they are spiritual but not religious?

SAI: umm if I say anyone in the ward I would say yes. Some of my staff colleagues, umm.. I have a close staff colleague friend that I would say that doesn't belong to any religion but knows about being spiritual. U know umm...

A: in your experience, I mean like you said; you have a particular religion, of course that is your way of being spiritual and you you also ... also mentioned the others who are spiritual but are not connected to a religion to a higher being. How do you suspect these people... what do they do, in what way are they spiritual if they are?

SAI: I think umm For me, being spiritual is connecting with like I say my religion guides me. It's where I connect with my God I would say right. For them if they don't believe in God but still being spiritual, maybe it's their belief system and maybe they got different guidelines to that. So umm in here in the ward, some of the clients who are Rastafarian they don't believe in God but they do believe in the spiritual spirituality in the Rasta religion or whatever. And I don't, it doesn't make them make me being the perfectionist you know. Because at the end of the day, they still a human being umm living a life according to a certain rule and guidelines and I think that's important. It boils down to exactly the same thing for me ... even though I might disagree with how they doing it... but not necessarily regard.. u know, disregard it.

A: so perhaps, from what I am hearing from you is perhaps umm guidance from something else outside of yourself are important aspect of spirituality. Now we talked really extensively about Shane* and the group, are there other people that strike you, u know, particularly in all your different experiences of being an OT?

SAI: Definitely, there is other, u say other than OT (A: no other than Shane* and the group). No there is another patient we had and he was he... you know when he came here psychotic when he settled, he would never take his hat off never cut his hair where in the wards where grooming is important. [A: self care/ hygiene?] Yar and we have to respect that he doesn't want to cut his hair and according to him, he's he.. belongs to a Rasta gang. Now, we all thought that maybe this is ... [A: this is sounding a bit.. doggy?] yar u know but when the parents came and confirm and said that he is but it's not dagga it's belonging to them and being part of his religion not part of his parents' religion but this is who he became. So that also stood out for me because that's against all of the things he grew up with but yet after hanging out and abusing using daggas and things this is who he became now. And it is difficult in the ward because now you got this boy with the hair and the other people they need to and he doesn't. But I think it is important to respect that person for...

A: so can did you explains to all the rest of teenagers who are obviously are boundary testing?

SAI: Yar, look I don't, that's nursing that does that. But I just know that he never cut his hair but you know what, when he was discharged and then we had a family day and all the family came in. He was one of the success stories that was discharged and that he was invited and he came and then his hair was cut.

A: the hair was cut?

SAI: so for that period I don't know maybe the difference now between him and Shane* is more linked to illness than him being...umm.. [A: because he didn't stick to it..to this possibly cultural practices] yar he didn't stick to it yar yar. So that's umm things like that stands out for me. Yar.

A: other people?

SAI: outside of the two of them... not really I think the regular customer patient that we see here, they religious they according to them now maybe they are Rasta and maybe they belong to this gang that gang. But it lasted only until a x amount of time till they know better and then you know .. they better and it's gone.

A: so then part of the deciding is to perhaps look at the duration, really does it stay?

SAI: And also developmental stage that going through so it's not easy for them to find identity to we should also not to forget that part. It's difficult being an adolescent but but more difficult being an adolescent with substance abuse and now even with psychosis, it's quite difficult.

A: now ok that's interesting I just say, as I just say that u know perhaps umm cos' you mentioned about this other boy where you he wouldn't cut his hair because he was so call part of a Rasta gang umm which seems that is the appropriate behaviour u know if he was part of that context. Of which later on you saw him and it was different umm didn't follow through what he said it suppose to be. And then you said perhaps consistency and the duration of things are important to us in deciding process. Umm but then you mentioned the different developmental stage of being an adolescent which in its nature it's all about changing and trying things out. So how do we tell.. whether it is a normal teenager trying different things maybe not cutting his hair for awhile and then decided I need to cut my hair vs. this is... religious, u know I am claiming to be Rasta and I am not going to get my hair but as I get better when I am out in my community I eventually did. What do you think are the factors perhaps one should..?

SAI: I think what you would look at is like what you said the consistency and the duration like with Shane* he went home and decided he is now gay if we can make that conclusion. But with the other guy he went home and came back and wasn't the Rastafarian. So I think if you can be consistent and in what you do then that obviously it adds to ... to who you are or what you become as suppose to then deciding this then deciding that which is also not wrong. Like I said with adolescents it's quite difficult cos' they change all the time. Umm ... but changing changing umm in terms of music and clothing is a different part to changing like Shane* being gay or something (A: yar a much bigger change than..). when it comes to Rastafarian I can understand the change that in the beginning you trying to be part of this peer group when you using substances because that's what make you part of the group. But then later on you decided no this is not working for me so now I am deciding to be not belonging to that group. So it is quite difficult to discern u know but yar...

A: now.. in Shane*'s case and this Rasta guy's case as well as the group, do you think you arrived with workable answers u know with their cases with regarded to what to do

SAI: I think the important thing for me umm is knowing that this is adolescents and umm with with.. I don't think I came up with answers but I have allowed .. umm I allowed space and respected that because what we teach them at the end of the day, is to need to respect one another who we are. And Shane*, sort of because he had this space, it allowed him to inner soul searching and find whatever it is there to find. With the other guy, the same thing; yes we didn't like it and but he still had to.. even through it's around his stuff, he still engaged in activities and it didn't make him different because at the end of the day he engaged, he received the same therapy that Shane* received and then he went home

he had time to reflect on it and now he had decided that I think that's important for us OTs that our individuals that we are enabling them to be as independent as possible and I think even facilitating their thinking process [as well] when it comes to what I want and what I don't want. They need to find that, umm even with the group, there wasn't a right a wrong but they the group listening to other members and came to conclusion you know of what to [do].

A: take this and take that bit [SAI: yar]. And now in terms of umm working through all these cases, were there particular resources that you find helpful that help you decide u know is this illness now is this perhaps.. something I can work with?

SAI: I think the patients at the end of the day became my resources because like I said for adolescents it is quite different to find articles specific to what you coming what you specifically dealing with in the group. Umm there is no books and things and I think the same they learn from one another the same we learn from one another. The fact that Alice* (psychologist) was there, we spoke about it; sometime I was emotional I had to vent and same with her. So we became resource for each other. And what came up for us was new things we can work with but there is no articles like I said. I never went on the internet to look for things, umm it was everyday it's different things that came up. That's how we..

A: So how do you, I mean there is a psychologist and there is an OT in the same group; where does occupation feature within the running of that group? Obviously there is also lots of discussions...

SAI: you see, I think that was quite interesting with our first group we .. Alice* facilitated the group but I was the one to come up with group rules u know. So you know the OT would kind of come up with (A: of course, hahaha...), Alice* would go on and on and I would stop and I say but I am referring back to rules now so boundary setting and things became out. Even though she was facilitating, at the end she would say you know what thank you for that I had never think about that and I would thank her because...[A: maybe she lifts some..] Yes yes issues came out that I just didn't know how to take further and she knew how to... And sorry, for OT for me, how did they concentrated how did they were able to stick to the themes that amount of time and their endurance of the group u know thinks like that. [A: u also looked at that?]. I looked at that.

A: Would you stop when they looked too tired or... what do you do after that?

SAI: I think it was difficult for different two professions. Because for me, you get the feeling the sense that now the group is tired and we need to stop now and the psychologist because there is more and more stuff coming out... [a: want to drill more in...] yar, so yar I am a very talkative person really open person. So you know, I would just tell her umm maybe we should wrap up now. She wouldn't go against that, but afterwards when we discuss it I would say why I did that. And she would, u know.. It's definitely

... it was a discussion group but you can see the different roles coming out there in the group of the psychologist and a OT.

A: Is she.. are you often the co-facilitating and observing and she runs the group or is it equal? Like one week you one week her you swop over.

SAI: u know what she .. I asked her to facilitate the group always I would be the co facilitator. I sometimes find myself where I u know take the lead now I need to intervene now. So I say she allowed me also u know now to facilitate that process. So yar...

A: and why did the group stopped?

SAI: the group stopped because Alice* resigned and she left. And we were without a psychologist I couldn't do it on my own. And then we started umm [A: and this psychologist just started..?] Just Monday. Yar started. So I then bought in music therapy where they would. Because that group it was like they were mute they never spoken about issues. [A: like expressing themselves?]. Yar but then when we had this platform, they were sitting with a whole lot of things. [A: the music or..?]. No I am talking about the same group [A:the spiritual...?] Yes, and after she left we brought in like music now. But Alice* left and the ward now became acute so that also ... I never thought about it now to continue. [A: on the other side?] Yar, It's difficult I am not in the ward. It's not as engaging the patients like I am here. I am based here I know these [patients] even through...

A: Is the OT program a lot fuller here compare to there?

SAI: No I think it's basically the same umm but here because I am in the ward I am with the patients all the time.

A: you have a office here and you don't [have an office there]?

SAI: no.

A: so it's physical location as well.

SAI: yes so when I do my groups there I do it and I come back there's no one...

A: so the six week happened here where you were based?

SAI: yes

A: Just lastly, how did you find the experience of having worked on these different cases spiritual issues. What's yours experience's like?

SAI: man, umm it was difficult to be professional and not to bring your personal things through the group. You know when they speak about a certain topic in the group, it gives you a time now to also need to now reflect. The only way we found we could get more things out of them is you come up with your scenarios you be honest about.. you share. So umm at times I was emotional because I also needed to vent because their stories became very...

A: It 'was really hectic.

SAI: yes, and then I umm... but Alice* was there and I think she was a good person to hold the space. [A: sounds like a tough group to run]. Yar it was it was.

A: thank you very much for your time, it was very interesting particularly how two discipline works together and the groups that you run. I think that now it brings us to the end of the interview.

Appendix 5 e: Transcribed interview with Kris

A: Ok, it's starting; so just wanted to put it in the middle. It should be fine and let's move a bit closer. Umm, before we start again, thank you for being willing to come into my study umm as you can see I am recording the interview which is for me to transcribe. But you can be reassured that I am the only person going to listen to it to do my transcription umm and so this study focus on how OTs decide about how their clients engage in occupations that speaks into the clients' spirituality so umm looking at how OT decide when they see their clients engaging in occupations that speaks into spirituality. Umm I wanted to find out how OTs use their clinical reasoning process to tell whether this particular engagement they are seeing is a health seeking behaviour or it's part of their psychiatric illness that they are experiencing. So to begin, I want you to tell me what your view of spirituality is?

KRIS: Umm I think for me the view of spirituality is... is anyone's connection to a force or an energy or umm .. and yar a force of energy they can connect with umm which is not necessarily tangential, something you can see umm and it can .. be ... it can affect them by what they are doing. And it can affect them by making decision about how or what they want to do. Umm I have to say that there is always a debate in my mind that .. or in the discussions I have had that spirituality is not religion and religiosity is not spirituality but my first instinct of working with people being in touch with a higher being so to speak, is in the context of religion [and] I think I have also may be dealt with people who talks about a positive energy that they draw on from other people or offer to other people and umm... what other context, something related to... umm umm something related to umm... like, what's the word; sort of like relaxation and peace umm.. meditation. Umm I would say that's how it comes out umm..

A: so it is umm, you are saying that spirituality is not necessarily equals to religion and religion [or] being religious may umm does not always equal to spirituality. Although that is the context umm in which umm you see a lot of the your clients and other people you work with that's the context that they take when it comes to spirituality. Umm, so given that's the context that spirituality is a force, have something to do with peace, umm maybe relaxation meditation as well as umm yar.. it's quite interesting that you talk about the force so umm in your view where you practising now, where do you see spirituality?

KRIS: Umm I have to I have to comment that we.. I don't have a special category and it's never been pronounced that we are looking at occupations that are influenced by spirituality. So I think it is a very subconscious umm reaction while we doing practising OT there's something specific to this person something specific that is meaning that is attached to what they doing and it may link to spirituality but I don't have a program design around it. [A: yar, to to get to it..] Yes. Umm... I think it is unexploded through, in our context so...

A: so, umm can you maybe give me some examples, when you say obviously it is not something, u know, there and it's designed particularly in the program but it is in the meaning people experience while they might be in OT groups or might be they may be in different things you do with them in here.

KRIS: like I have a person that is currently working at, just one example; he works at.. umm in a garden in a garden where he does gardening. So he's very much in tune in touch with nature. Just same time, it happens that he happens to have delusions that umm certain power that comes from the Earth that can influence him umm or that gives him messages and signals. So often when we have a conversation when I go visit him how's the work going and what's you been doing. He would within the context of talking about his practical steps of what he's doing, he's also telling me about the messages he's picking up and that you know I can see that in his perspective in this point in time it's been a positive experience. U know he's immense in his work and his connection to the Earth. And it hasn't been a negative experience thus far. Umm It is a concern for me, I always wonder if ever at one point where he would be perhaps getting a negative energy and that it may influence his work performance but to date it hasn't come up yet. Umm But this is one example that I thought this man is enjoying his occupation not only because of the productivity, and activity or the practical [A: of the practical .. but also how he interprets...]. Yes which is very much integrated into his psychotic symptoms I have to say.

A: and you are saying that to date even through it is a concern, it is not something you... you would not necessarily go in and do something because as you can see that he seems to be enjoying umm beyond just the practical the actual doing of the gardening.

KRIS: So I thought... when I... it wasn't, it wasn't a deliberate job match but the more I got to know him while I work with him, I realise that it was actually quite a good match spiritually also in fact more than that he could do the job.

A: what was the original job match...?

KRIS: It was just a vacancy became available and he told me he's interested in gardening so umm because of his past experience of having done that kind of work but it's also been a hobby for him when he was at home umm so I think ok the job match is that he's got the skills he's got the history and experience and he actually enjoy it but then I actually found out that there's more meaning to him than that.

A: and how long has he been ...sounds like he's currently still?

KRIS: Yar he's currently still there and he's been there for about 2 years now. [A: so quite stable] yar very stable umm interesting actually, I would say stable and okay. But he came to visit us in the ward round the other day, he was sitting in a multidisciplinary team and he's started talking about his connections and the powers how he get messages from certain plants. And then the whole team was discussing that he was clearly psychotic.... [A: haha]. And it is true, there is.. he is thought disordered and psychotic but at the same time I could see that it was meaningful [A: and he's engaging and in a way functioning in his.. one of the areas where OTs would be concerned about, is he still a... in the ward?] He's in the ward and he's somebody that wouldn't have the privilege of leaving the ward to... except for a day or two maybe. But otherwise ... cos' of the circumstances he was in when he was admitted here that's the most he would ever gets in terms of leave from this hospital. Yar.

A: So he goes out to this.. whether he works everyday which is outside of the hospital?

KRIS: yes, he does get out.

A: Which is outside of the hospital? And he goes in and out by himself? [KRIS: yes] Sounds quite responsible actually.

KRIS: yar yar that all started with new friends when he started working and another spin off is that he goes shopping all on his own. Okay, that's not really spirituality hehe.

A: But it's interesting how engaging in one occupation which I think to this person which it is slightly interpreted in a spiritual way [KRIS: absolutely] that spin off, the benefits of that umm spread across to other areas as well.

KRIS: I also think it's it's ... I really believe that it is one reason why he's actually being... why he's been able to sustain his employment status because it really has positive meaning to him.

A: so he does not participate in the... cos' I know you guys still run other groups for people who are in the ward who's not actively engaging with work outside so he doesn't get a chance to do...

KRIS: ah... he chose not to, he used to before he was working he used to do some groups. But he chose not to do any now that he's working, so he would do his job come back and relax and look after his ADL stuff, shopping and that kind of thing.

A: Did he ever say why he chose not to...?

KRIS: Yar cos' he is tired hahaha, and he feels like he's got his washing to do he's got his shopping to do and he doesn't feel... [A: so he doesn't yar... that's enough] He was in fact an extremely good artist and I am still trying to get him to try and participate in an art group or actually I wanted to set him up in doing his art on his own in his free time in the ward. [A: for a bit of balance?] yar, because he was extremely good at it and he enjoyed it but he decided not to so we going to wait and see when he's ready again. Umm I haven't spoken to him in detail about the implication of what he gains from participating in art other than I can tell you that he is an extremely talented artist. Ok.

A: so I think in this example umm the the occupation engagement that spoke to this particular person's spirituality was umm... a positive one like you said more a health seeking one despite when he comes in to ward round that the opinion is that he is still psychotic obviously cos' he talks about the power and things like that, are there any umm.. clients you have worked with where it is the opposite? Where their particular engagement of .. that is seems to speak to their spirituality umm is part of the illness?

KRIS: I think that's gets a little bit more complicated cos' now we definitely we definitely talking about psychotic symptoms and like I said in most cases it is related to religion or like so... I will give you an example, two weeks ago I had umm.. somebody who umm has been working extremely well in the open labour market for at least four years now and he had never had a relapse during that period he's never been off from work during that period due to his psychosis or religion or no.. psychosis basically. But then he started to get these special beliefs that he was getting messages from different signs that were set up at work. That every sign has a special meaning attached to it that affected his perception of how he see other people at workplace. [A: It's almost like the signs are telling him something about the people around him?" Yes. And so I don't know if you would classify that relationship with spirituality but what it came across to me as is that he was getting an external message umm and he was very much in touch with that external message as a real message to him.

A: So in touch that it kind of affected him in his role of... working there.?

KRIS: Absolutely. He started being paranoid about his manager and some of his work colleagues to such a degree that I was very concern that he was going to harm them. [A: is this the person you were talking about you brought him in wanting him to be admitted?] No, not the same person. And then we saw him in the team at the ward round, we decided to give him a work break from the work context where it seemed like all his negative messages were from the workplace and from the work environment. So we gave him a break from the work for two weeks and then we went to do a home visit and see how he is coping there. He was speaking less about the messages and his environment was more contained. [A: yar]. So then we went him back after two weeks, back to work and he's working fine and everything is okay but now he shifted his his his umm delusions onto his home environment as in he started getting negative messages from home no longer the workplace which now has implication for... like now is he u

know is he going to harm his mum cos' he lives with her. As a result, what we did was we removed him from that environment [A: from the home?] yar and asked him to come here to live in the hospital for two weeks but still continue with his occupation of work.

A: so he's... I would imagine someone who... I know your patients don't get discharged almost ever, so he is kind of like an outpatient on the books... [KRIS: yar yar... yes he gets leave, extended leave of like 3 months leave] and he would come in to see you guys in the ward round.

KRIS: and I follow him up weekly in supported employment, I have regular contact with him in this 3 months out of the hospital [A: so he's now living back in the hospital?] Yar [we] would have to assess what he's sense are umm...

A: what's.. I mean... was there any discussion of what the trigger was? He sounds like he was very stable for four years in the same workplace with the same people.

KRIS: yes exactly, very supportive people. It is something we can't put our fingers on we initially try to figure out if it was umm non-compliance of medication. But the way the result in the interview with his mother, and she's also someone with experience of looking after someone who's ill so she said she supervises his medication so he's been definitely taking it. So that kind of factor that we think okay that's he's compliant. And we can't think of anything from the interview with him with his mum what significant stresses. Because things were going really well at home and at work so what they have done is that they have looked at his medication his dosage and actually think that he is on the maximum dosage of what he needs to be. So we actually sort of concluded that part of his.. the cycle of his illness, that some point in time he's going to relapse [A: yar, that it needs to come and part of that]. Yar. Umm maybe there isn't a significant trigger that is in the case.

A: I think that it is still great that umm it doesn't have to be a full blown really problematic relapse... that he can be supported so quickly that he could come in get stabilised again and...

KRIS: yar and continue with his occupation, that he's still living here working and coming back. That's a good thing I think.

A: now you mentioned that for a lot of the clients you work with, that religion is the context in which they experience spirituality; given the fact that they are long term people that who lives in the wards here... I mean I am not sure what are the percentage of maybe that would never leave the premises of the hospital umm umm are there anything umm in the program that the teams put together that umm perhaps address this issue?

KRIS: Umm I must say that as a team, the a forensic unit when we had this planning discussion around bringing in something around religion there is a hesitancy from psychiatry side, because some psychiatrist believes that it could umm enhance some people's ... it could heighten their sense possibly, [A: possible make their delusions worse..]. it could make their psychosis worse so they wanted... they tried to establish that we should not engage directly with religious umm activities. But we do really know that there is a pastor that comes in here and have a services that people can come and attend that. Umm and I also arrange for 3 or 4 of our clients who would love to go to church on a Sunday so they go to observatory every Sunday for an hour on their own. [A: oh, with the town parole?] Yes they will get their town parole and they would go and they are regular and they go to their service on a regular basis umm so Bianca* and I were discussing maybe other types of religion because this is focus on.. very much focus on the Christian faith. [A: yar the church the pastor coming in]. Yar, exactly. We needed to look at something more all round but we haven' actually done anything specifically yet around that. Umm, yar. We have a yoga class and I think there are some people that find it very spiritual umm in additional to physical, I have seen that and they are quite at peace and they quite enjoy the attitude that comes with the yoga therapist; very open to... umm meditation. And I seen that it's been quite good about concentration but what was interesting is that one of my staff members because of her own religion she decided she couldn't participate in supervising. But I haven't had a patient who would refuse to go to yoga because of their religion but I noticed ... it came to my attention that it is possible. So it affected one of the staff's occupation actually. [A: yar it's part of her actually working here]. Yar. Umm.... Yar..

A: umm.. there was that one particular person I asked you about before we started this interview umm should you describe... cos' what I know about him is that I don't think he was a forensic guy he was an acute person who was also quite long term in the supported employment program and he was working at spices I don't know for how long umm but umm at times he would becomes quite religious and things like that yar, can you tell me more about him?

KRIS: Yar umm once again if I describe this case study, for me it's not spirituality issue but it is almost a very clear psychotic issue but okay we can go ahead and analyses the context. This is a man who had probably worked for three years but he's always have had a level of symptoms presents, he has a fixed belief systems about two issues: 1) he.. the colour of his skin is not somebody who's from Indian origin and he's actually classified as white so he's got that belief system going. And 2) that he was born into a family with a religion of Muslim umm origin but that changes from time to time sometime he is a follower of Islam and sometime he is a follower of Christianity and but at the same time he was living with his aunt who's a Hindu so it was quite a complex mix of everything. He's not somebody everyday who's act are influenced by his religious belief system I could see that.

A: So he's not someone who's usually so religious that religion would influence what he will do?

KRIS: yar but it would come out in small ways like umm like his aunt could be poisoning his food but I didn't see that as a religious issue. [A: ok, so it's more the context of...] a psychotic symptoms. Yar so I don't know what what is it about the case that trigger previously an opinion that it is...

A: I think, cos' I don't know... because I only know him from the couple of weeks when he was with me in my system and he was always going by a particular Muslim name [KRIS: yes] then he suddenly, I saw him recently at our department and he said he's was something else and I thought no maybe he's relapsing. But then I checked with another colleague who work with him more at spices who said no, he did change his name to that after he became a Christian... So, through my working with him, when he was ill he would not shave not cut his hair and does that affect how he works at spices?

KRIS: Yar absolutely we had to talk about it basic work habits presentation that kind of thing but I think it was a typical symptom of schizophrenia where you start neglecting yourself care I didn't pick it up as it's because of his religion umm that's he's now stopping washing stopped bathing kind of thing. He had been very much affected by food and become very paranoid with about how people make his food who's poisoning his food. Umm I have seem like you said the change in religion umm

A: so it's almost like change of religion is more an indicator of him starting to get sick again rather than engaging in [KRIS: and taking on it fully].

KRIS: Yar, I have another person that every similar umm as in like he often has two religion in fact I saw him last week. Now he is very interesting because he is .. when you speak to him, everything is based on from a religious perspective. Ok. But he's got both, he follows the Islamic faith and he follows the Christianity faith. And it's interesting because he has to go to church, he's one of those people who has to go to church [A: one of the four (that has town parole for Sunday to church in observatory)]. Yar and umm but at the same time u know when it's Ramadan and Muslim fast he also want to fast.

A: now that's interesting cos' is there ever an exception for patients who are Muslim and umm the strict running of the ward ... u know this is a mealtime and... do they ever get opportunities to engage in fasting and things like that?

KRIS: The fasting issue we have discuss very at length with the clients, it's a very client centred approach then. And in most cases it is advised and appropriate to the religion that people don't fast because they are on medication. [A: because they have to drink water with it?] Yes and that sometime they need to take it during the period they have to fast so we have some clients who told us they want to fast and we adjusted that month for that month we try to make it [A: oh, to make the medication work in such a way that they can.] Yar so we say after 8pm or but it is highly recommend that they don't but I have someone that does fast and who has become an extremely religious person and because of his religious beliefs not psychotic based, he has.. his his all his activity and occupation base has been changed. So he

found religion again, Islamic faith. [A: is this the same person again?] No, a different person. He's living at home, he's also a forensic client, he gets 6 months leave at a time. And I don't know how it came about that he had met a group of people who are really really religious and he joined that group. And as his new faith and his new depth of faith all his occupations had changed. So for example he prays five times a day, that means he gets up early in the morning and he goes to mosque and spend some time there [A: everyday?] yar everyday. And he also goes to classes everyday where he's learning again. He's also started travelling with a group of people who go and pray at different area of mosque. So all his occupations are changed. [A: what was he doing before?] Before, he was.. the main thing that he still does, is that he has his own little business he sells spices. So during the day he prepare his packets, two or three days of the week he does his preparations and other days he sells that which he still does. During his free time nothing much and he slept quite a lot. So the influence of his his attachment to religion had made him more active. [A: yar if he has to structure himself around the 5 prayers every day...] Absolutely yar.

A: so he goes to the mosque every single day to pray? 5 times a day all the time?

KRIS: yar he spends a lot of time in the mosque. It concerns me a little bit umm [A: how come, why does it concern u?] I am trying to think.. u know when he was first admitted to *[name of workplace]* within the forensic context, he had this umm ... he had this belief that there was this woman that umm he had ... he believed that he was in love with this lady and she was in love with him and that they had a relationship going but umm in reality they had absolutely no relationship and he.. what happened was that he had plotted a umm.. trying to harm her husband umm because in his mind they were having an affair so yar he had gone there and committed quite a violent crime against her husband of this woman and the one thing I remember that the same man was belonged to the same mosque that he started to become attached to. So my concern was to be in contact with this woman and husband again and it might just trigger the same... [A: that feeling...]. Yar that was my concern but otherwise otherwise that's what he found. He doesn't smile, u know, I mean he doesn't he doesn't yar... he said that's what he has to do and he's very serious so I can see the meaning and I can see he is getting meaning from the activities but I don't know if he's enjoying or pleasure or whatever he means..

A: yar doesn't seem happy when he doesn't particularly smile.

KRIS: yar, but there's a very personal experience

A: umm I am quite interested in your comment about that very often that religion is often attached to a lot of the psychosis and the delusion context, is it true that perhaps spirituality is something more positive? Or less... ummm or there is a slightly clearer line of away from religious part of the delusion?

KRIS: In psychiatry? [A: um]. I think it's not clear in psychiatry umm I think that the minute somebody is... religious conscious there is a sense of ... umm anticipation of the person could be religiose [A: like a flag going up that this is part of delusion?] Yar I some context it is true but it is not in.. like somebody could become so influenced by their religion that they overindulge in their activities that are directed by that. Typical of someone that could be manic or I also had some people who became very judgemental of other people because of their umm religious beliefs so the behaviour is affected. So, to answer what's your question again?

A: More umm.. because you are saying that religion in psychiatry is quite often attached to psychosis so that in that sense we are saying that it's like almost a flag is going up as soon as someone comes in and start talking about religious content to what they talking about, whether it is a positive or negative thing or not umm and you were saying that spirituality in psychiatry there is not a clear distinction between

KRIS: I think more umm that is a discussion in a multidisciplinary team in a ward round setting but it doesn't influence our occupational therapy intervention all that much I think for us, for me not for us, for me when we working with a group of people or people on individual basis where do they find the most meaning? And what would be their description of meaning be? Cos' some people it would have a spiritual dimension but for others it would be have a very concrete dimension like poverty alleviation. Umm so I take each person's meaning and experience of meaning... and then some will have spiritual implication and I will draw on it from there.

A: and because we are saying that it's a difficult thing to tell in psychiatry, are there any particularly places where it is difficult for you to tell whether spirituality is a positive thing or a negative thing for this person?

KRIS: umm I think often that .. I can tell you from my broader experience is that when I seen people very psychotic to such a degree that they find it hard to participate in a conversation or an activity for a long time and if their symptoms are religious based, then yes it's almost always a negative impact. So because yar they are making a reference a lot to religion and to outside force and to something external and okay and that's very close to be out of touch with reality and close to the psychosis. [A: yar especially in the context where they can't engage...] It would be fair to say that religion is a common denominator in people's who are actively psychotic. Absolutely. And in that insistence I would definitely not encourage discussion around their religion and their beliefs because I feel like it just bring out more thoughts. Umm so in that way, it is better for me to keep away from the spiritual dimension.

A: and for u, it does sounds to me that you have dealt with it in many different ways in many different cases, what do you find helpful, is there any resource or people for you is useful for you when you're thinking about a particular person that's occupations that may speak to spirituality?

KRIS: I think, yar I will give you an example.. as you know, a lot of my work is about supported employment, and often I work very closely with the employers as well as the people who are working there. And sometimes I find that the employer or the direct manager also have their own component of spirituality which they bring into the workplace and that influence my workers. So for example there is one lady who's very much encourage religious, like before they start their day everyone gets together they stand in a circle, somebody says a prayer, it can be anybody any kind of prayer. It can be an Islamic faith or if you are from a Christianity base. Somebody will pray in the group before they start their day. And for her, it is a positive motivation to get everybody ready for the day, a very peaceful frame of mind.. [A: yar it's like another team building] yar.. and I was very very struck by it cos' all the workers participated willingly [A: all the workers?] Yes all the workers not just my workers. I thought it was a very very good approach in terms of her giving their minds and body ready for the day and it definitely added to the motivation for them to work so I found that positive.

So okay that's one example. Then again relating to the partnership with the employer, remember the guy that I have spoken about the gardening... [A: yes]. Now, the person he works with, he's also very much a spiritual person umm and he's extremely in touch with nature and getting energy from nature. So the relationship between the two of them are dynamic, because they just clicked. Umm they get the energy level [A: yar and that does contribute towards the client able to work very happily and well there for a long time]. Absolutely, so I thought that's great and it's not something I can actually offer my clients but clearly they enjoy it. [A: it almost sounds like the environment in which you situate your clients also becomes a resource to you as well]. Absolutely absolutely I have seen that many times. I have also seen some of our volunteers in our group work, u know what they bring as a person. As you know we have the pottery going and I have seen it in our yoga class. That as individual people, they are extremely spiritual in their own way umm the one draws on energy source and the other one draws on meditation and that captures the attention of our clients and they have discussions around it and they talk about it and I found that it is more than just doing the pottery then and it's more than just doing the yoga activity.

A: do you think it is harder for us to have that kind of spiritual discussions with our clients sometimes?

KRIS: as therapist? [A: yar, I mean cos' you talked about the context of the team, at least certain part of the team wanting to keep it away] yar out of... yes I think yes to a certain degree we are more hesitant and less natural in just promoting spirituality because of the context of of influencing somebody's psychotic symptoms if I exacerbate it and if someone have a physical disability I would probably have a completely different approach.

A: And umm lastly I wanted to ask you in terms of your feelings and experience of in dealing with clients' occupations that speaks to spirituality, has it been a pleasant experience has it been not much a pleasant experience in some cases?

KRIS: umm I think for me, it's been a more positive experience but I have to say again it starts off with me talking about what was meaningful for that person and tries to understand from their definition of what gave it meaning and if it turns out to be spiritual related then obviously it's positive. Umm has there been a negative experience? Umm ... well u see then I would not classify it as spirituality if I am talking about someone who is completely psychotic and religiose. I wouldn't classify that as a spiritual umm dimension that had made this person ill.

A: just another question I am interested in, you were saying you and Bianca* are, having had the discussion with the team that religion is kind of something umm sounds like the team wanted to avoid. And you are saying well perhaps to look at other ways of... getting into spirituality umm what are some of your ideas more as preliminary thoughts on that?

KRIS: well there are a few things. The one umm is ok the one is religious related as in like I would like to broaden the umm.. accessibility of having to have access to the religion of choice. At the moment that Christianity is a very big force in this hospital, in fact the only one. So we haven't explored partnership with different religions.

A: What are the... in terms of the clients themselves what kind of religion are there?

KRIS: I find people there are Rastafarian that classify that as a religion. There are Christian faith and there are Islamic faith umm that's the three most outstanding, sometimes there are people with Jewish faith umm .. [A: so certainly the Rasta faith and the Muslim faith is not being represented in what is accessible?] Yes yes absolutely. So I wanted to look at that a little bit, around like is there opportunities for them also to have a session like either a Sunday morning session? Is there an opportunity for themselves or for someone lead a discussion or follow their interest in their religion if they had any. The other very practical thing is that like I am trying to get the hospital system to change like u know everybody has meals together and they pray, they always pray... and it is always a Christian faith based prayer so when I run my cooking group we have to sit down and have a meal then we would have like one from each that are represented there. So ok we try to make it as dynamic as we can and as respectful for everyone as we can for everybody. I noticed that it is maybe an institutional symptoms for those who are not in tuned to religion maybe they look like they don't care. Somebody just pray in a different faith, they are just going to have their dinner now and it's okay. I don't think it's their biggest fight but it would be nice where we have a system okay, let's have a look at everybody's faith system in the ward and then we have a small prayer from different person from different faith.

A: I do find that quite staff driven and it's quite depends on what the religion of the staff is. And it's most likely Christian unfortunately. [KRIS: yes yes].

KRIS: So that's would be something quite practical that I would like to change. Then away from religion I would like people to be more in touch with nature. Because I have found that it makes a huge difference in the umm state of mind and their behaviour and that they are peaceful and they are very much calm.. So, one small example would be we had an outing one day we went and spend 5-6 hours at Kirstenbosch and somebody took us through a walk at Kirstenbosch [A: like a hike or a trail?] yes like a trail and afterwards we came back we sat on the lawn and we had a group umm and it's just peaceful and quiet, the view is fantastic and everyone was peaceful in touch with nature and trigger a lot of previous memory of them being in touch with nature and all of those memory were positive. Like passive behaviour nothing aggressive. So I thought for me that was a remarkable day and I thought if we had more activities that are set in that kind of natural environment that it would influence people. And like when we go to the beach, for a lot of our clients; the sea water have some kind of significance. [A: yar, I always see them bottling them up]. Absolutely, so that's another context of nature so I would like to look at those types of activities.

A: Is there anything else you would like to add besides what I had asked?

KRIS: I can't think now, maybe I don't know.. Umm.. yar. I think maybe also the one thing that strikes me umm remarkably is that the profession of occupational therapy we have never, not once in the 13 years I have worked here in the department that we discussed spirituality as a dimension of occupation. [here?] yar, it's never been on our agenda. So umm that's significant.

A: do you think this is a similar trend in other APHs, it would not be something that would have had a space to discussed in the department?

KRIS: I think, I don't know men, but for me; I have become a lot more conscious of it when I have studied my Masters so I don't know if it's an issue of being expose to literature and to yar like the latest discussions of occupational therapy and yar that would influence your discussion into your planning and your vision around that.

A: although I don't think people in our department is unspiritual people.

KRIS: no [yar that's interesting] but that's on an individual bases [Personal not professional] But I am talking about spirituality in occupation I mean that's something that you can learn about and bring into your program. And I don't think we have consciously brought that into our program or our vision umm I think the closest we can link it to is meaning.

A: thanks very much for your time I think we do have to end there.

Appendix 6 a – e: Stake worksheet 3 for intra-case analysis of all 5 participants

Appendix 6 a: Stake worksheet 3 for intra-case analysis of Imani

Stake (2006: p45): Adapted Worksheet 3 – Analyst’s notes while reading a case report

Code letters for this case: Imani

Case study report title: Imani’s experience in discerning degree of healthy giving-ness or ill health-ness about spiritual occupations.

Analyst’s Synopsis

The case: A 36 year old Muslim **brown female** occupational therapist with 15 years experience in psychiatry. Imani is currently in managerial role within **her** department.

Imani’s view on spirituality in her workplace:

1. “Spirituality is ... [a] connection with something bigger than you” (1) that is unique and subjective (2) and observable (4). It provides a sense of balance and inner peace. (3)
2. At the neuroclinic, it is uncommon to have clients with ‘spiritual crisis’ and that even through connections to others do happen, it is artificial and short-lived due to it being a 6 weeks program. Furthermore, spirituality seems to be enabled through allowing personal space in the neuroclinic.

The sites: Imani describes scenarios in two settings he/she had worked at, i.e. a neuroclinic and intellectual disability contexts. Imani is expected to be more than an occupational therapist in this setting, she is required to manage cases as well.

The activity:

Neuroclinic has a 6 weeks program for the maximum capacity of 12 individuals. As the clinician at the setting, Imani's main role had been as a case manager, run cognitive lifeskills groups, relaxation groups and encourage leisure occupational engagements.

Imani had multiple encounters with discerning clinically about her clients' occupations of spiritual nature, they are summarized as follows:

- 1) Muslim women wearing full keejap in neuroclinic.
- 2) Non-communicative Xhosa preacher with dual diagnosis of schizophrenia and intellectual impairment doing repetitive gesturing.
- 3) Lay counselor doing ministry in the neuroclinic.
- 4) Rastafarian and use of substance

Key information sources: Interview

Context information

There are explicit rules and unspoken cultural norms at the neuroclinic in terms of its expectation of clients' behaviours. The wards' rules do not encourage engagement with religions. However, these rules seem to enable other spiritual connections other than with higher beings through leisure occupations or participation in groups.

Situational constraints:

1. Imani is not currently working in the same context where most of the discussed experiences are from. This means that the cases could have been described with more details if they were more recent.

Prominence of Objective 1 in this case: High (Political reasoning)

Prominence of Objective 2 in this case: High (People & organization: * Model of Gut)

Prominence of Objective 3 in this case: Moderate (Both enriching as team member & uncomfortable as expert)

Expected utility of this case for developing of themes towards Obj. 1 (CR): High

Expected utility of this case for developing of themes towards Obj. 2 (resource): High

Expected utility of this case for developing of themes towards Obj. 3 (experience): Moderate

Possible excerpts for the multicase report:

1. Clinical reasoning about spiritual occupations is complex, dynamic and multi-layered. It often begins with curiosity and desire to understand clients' behaviour.
2. There are critical checkpoints in the discernment process: a) is this a spiritual occupational engagement? and b) is it a health giving or a symptomatic spirituality?.
3. When discerning, look for the meaning of the occupations, the appropriateness and consistency in the time and context. The action taken post-discernment is further influenced by considering the individual benefits and harm and the population in the ward.
4. Resources come in the form of people – the clients and OT themselves, other team members as well as external organizations.
5. The experience of such discernment is enriching when diversity in the team is acknowledged or leads to better understanding of the clients. However, it becomes uncomfortable when one is expected to know as an expert if one is from similar origin of the clients.
6. Reliance on one's own intuition ('gut') is also a helpful strategy.

Commentary <NB>: This is an interesting and complex case. It seems to be enriched by Imani's work and lived experiences. Religious practices formed the background of the different cases Imani spoke about, however occupations still come out as the expression of that person's spirituality.

Imani was more reliant on her 'gut' feel than external knowledge. Rules in the ward also seemed to be an important factor for decision as well.

Intra-case analysis for Imani

Theme 1: The multi-faceted & layered process of clinical reasoning towards action by different players

Sub themes 1.1: The process of discernment

Categories	Nodes
1.1.1 Clinical reasoning process about clients' spiritual occupations is a dynamic and complex process where multiple factors are considered at various levels and often initiated because the team wanted to understand the client's behaviour.	<ul style="list-style-type: none">• Clinical reasoning is a dynamic complex process• Not only what spirituality but is it really spirituality is asked in clinical reasoning spirituality & clinical reasoning is useful thing to think about• Dilemma regarding effect of spiritual occupation for one vs. many clients• reason lead to wanting to understand spiritual like behaviours

1.1.2 Factors to consider while discerning

1.1.2.1 What is the reason for this 'behaviour'?

- Consider reason behind pt's behaviour

1.1.2.2 Is it consistent?

1.1.2.2.1 Health giving spirituality is consistent

- If behaviour is consistent - more likely to be healthy spirituality

1.1.2.2.2 Consistency should translate across expression in clothing to general behavior.

- Consider if particular behaviour is consistent with the rest of you

1.1.2.3 Is it beneficial or harmful to the individual and/or the system?

- weighing up behavior's harm& benefits

1.1.2.3.1 Degree of benefits and harm for the client in question

a) Will it do any harm to the individual?

b) How does the client feel about it?

c) Will it affect how they benefit from team's intervention negatively?

- Consider indiv vs. population benefits & harm

1.1.2.3.2 Degree of benefits and harm for the individual vs. population

1.1.2.4 Is it appropriate?

- Consider the spiritual behaviour's appropriateness in the context it occur

1.1.3 Observation at the time and over time is an important tool to inform clinical reasoning on spirituality matters.

- Consider the spiritual behaviour's appropriateness in the context it occur

1.1.3.1 During interactions at OT groups

- Observe in interactions

1.1.3.2 Over time

- Observe behavioural change over time
- incongruent clothes for spiritual expression

Sub theme 1.2: The actions

Categories

Nodes

1.2.1 Taken by client

- clients negotiate for space towards spirituality

1.2.2 Taken by team

1.2.2.1 Taken on case manager level

- Spirituality issue first approached by Case manager
- double checking with clients if 'expert' or case mx unsure
- Negotiate with client to moderate their own behaviour
- To explain the purpose of program

1.2.2.2 Taken at team level

- MDT discusses what to do with the indiv.
- Nursing staff monitored

Theme 2: Resources in the form of people(s)

Categories

Nodes

2.1 Other team members

- asking for assistance - match client to informant
- case manager do indiv. report back & questions
- draw on MDT experience on appropriateness

2.2 Client themselves

2.3 External organizations

2.4 OT her own lived experiences

- clarifying to understand spirituality from client's perspective
- consult external experts e.g. organisations
- not reliant on theoretical models
- Western training & experience in psy impact on how to work with sp
- lived experience impact on how OT work with sp

Theme 3: Experience & Attitudes

Sub Theme 3.1: Discerning about clients' spiritual occupation is an enriching experience through it can be uncomfortable when one is expected to know.

Categories

Nodes

3.1.1 Positive experiences: It allowed respect of diversity amongst the team and it is not always too challenging.

3.1.1.1 Positive experience for the team

- allowed appreciation of diversity within team
- better understanding of client through consulting other team members
- most CR using existing knowledge is not unpleasant as they are not always difficult

3.1.1.2 Positive experience for IMANI

3.1.2 Negative experiences: It is uncomfortable and unsuitable to be expected as the 'expert' as one may not know enough.

3.1.2.1 Negative experience for the team

- team member similar to pt automatically become spiritual expert - uncomfortable expectations
- falsely perceived capacity & expectations of 'expert' because of supposively cultural similarity

3.1.2.2 Negative experience for IMANI

- being the only one in her own background while more dominant bg's there r multiple
- Problematic to be called as an expert

3.1.3 "I don't always have the answer."

Sub Theme 3.2: Attitudes from OT & MDT that enable or limit spirituality in the neuroclinic.

Categories

Nodes

3.2.1 OT herself: "so I am bit more of a gut OT"

3.2.1.1 The model of my gut: trust my instinct & respect client.

- model of 'my gut' (IMANI's philosophy about working with spirituality)

- trust own instinct
- Have healthy respect for behaviours
- We are all equal even though we may come through diff life exp

3.2.1.2 Curiosity about existing models.

3.2.2 The team

3.2.2.1 We are reasonable and we will negotiate as long as system comes first and that spirituality is not engaged with *loudly* in the ward.

- Nothing wrong with what you do but where u do it
- MDT up for negotiation with clients but with a definite boundary line
- system take priorities above all

3.2.2.2 Institutional low expectation of clients.

University of Cape Town

Appendix 6 b: Stake worksheet 3 for intra-case analysis of Jose

Stake (2006: p45): Adapted Worksheet 3 – Analyst's notes while reading a case report

Code letters for this case: Jose

Case study report title: Jose's experience in discerning degree of healthy giving-ness or ill health-ness about spiritual occupations.

Analyst's Synopsis

The case: A 29 years old Hindu female occupational therapist with 3 years experiences in acute psychiatry.

Jose's view of spirituality in the workplace:

1. "Spirituality is the way how a person feels about their higher being [and] how they feel they need to connect with the higher being so it can be through prayer or living a specific lifestyle".
2. "If you look at our catchment areas, ... where drug is prominent and low functioning people uneducated people [live]. So it's very rare that you would see like a high functioning with like an Earth child person..."
3. "[For female], I do this because it makes me feel good and makes me connect to God..., with the female I found it's about how I live my life that I can connect and it's not what I have or what I get back [as in males].

The sites: Jose is working within an acute service. He/She has experiences in both male and female admissions. As stated in the "role of occupational therapist" document Jose provided researcher, the following is a summary of her roles:

- Assess lifestyle, communication style and influence of illness on daily functioning.
- Liaise with employer about patient's admission and sick leave arrangement.
- Refer and recommend work assessment and/or rehabilitation or return to work.
- Refer patient to appropriate resources outside of the hospital inpatient system.
- Psychoeducation and drug abuse awareness.
- Life skills around lifestyle management.
- Therapeutic craft activities.
- Train students and supervise volunteers in the admission system Jose manages.

The activity: Jose manages vocational rehabilitation facility in the morning where different clients will be incorporated as well as afternoon leisure groups (min. 4 per week with 6-8 clients in a group depending

on group activity.)

Jose had experience dealing with spiritual natured occupations through working with some of her clients as summarized as below:

1. Becoming a sangoma
2. 'Born again' Hindu (Christian) obsessed with Durban & Hinduism
3. Hippie person - connect with nature & self
4. Rastafarians - frequently seen & hard to discern

Key information sources: Interview and information on OT service as printed out by Jose.

Context information:

OT is required to take a population approach due to the number of clients, hence they have to slot into existing groups within the program. There is an unspoken rules regarding not to encourage discussions on religion (despite clients identify it as the means for expression of spirituality). This is practiced for the avoidance of potential chaos in groups. The unspoken rule becomes more flexible while Jose engages with clients individually.

Situational constraints:

- Acute: fast moving and requiring OT to take a population approach with fixed program to provide both quantity and quality within the constraint of resource.
- Due to the assumption of acute being a symptom dominated stage and they are moving fast through the service, spirituality is not a priority in treatment.

Prominence of Objective 1 in this case: Moderate/high (weighing up process, look at balance)

Prominence of Objective 2 in this case: Moderate/high (Google)

Prominence of Objective 3 in this case: Moderate/low (straight forward, no struggles)

Expected utility of this case for developing of themes towards Obj. 1: High

Expected utility of this case for developing of themes towards Obj. 2: Moderate

Expected utility of this case for developing of themes towards Obj. 3: Low

Possible excerpts for the multicase report:

- Clinical reasoning is a dynamic “weighing up” process over time. It is aided by observation of multiple factors— history, here & now, future plans, contradictions and theoretical bigger picture
- Action are taken to understand and modify clients’ behaviour through education and negotiation at the ‘right time’.
- Multiple sources of knowledge are used in the discerning process. This includes collateral, academic literatures and information from the internet. The preference is 1) within the team or from people who knew client before admission, 2) online and 3) OTs outside of the team.
- It is unpleasant to be seen as an expert despite such discernments is experienced to be straight forward due to its likelihood towards being a symptom.
- There is tension between biomedicine and OT philosophy when clients’ perspective is considered.
- Conflicts amongst the team, clients and their significant others due to differing view on the spiritual natured occupation(s)

Commentary <NB>:

- Jose began by defining her view on spirituality being a connection with higher being. Hence spiritual occupations are means to seek such connections.
- She described two cases that are specifically local (i.e. the sangoma and the rasta’s). Perhaps because they were anticipated, it was a surprise when Jose spoke simply of her overall discernments was straight forward.
- Jose emphasized on the importance of understanding the behaviour in its context while consider balance of life and developmental norms.
- In Jose’s opinion and experience, spiritual occupations in her work setting are often part of clients’ symptomology.
- Jose found the experience of being a cultural consultant was an uncomfortable one.
- Jose compensates for her self-perceived lack of knowledge with internet searches in cases mentioned.

Keywords: Collateral, spiritual behaviour of symptomatic nature, conflicts, weighing up & the ‘right time’.

Reference

The role of the occupational therapist. Male Admission, workplace of Jose.
(Note: name of workplace removed due to confidentiality)

Intra-case analysis for Jose

Theme 1: Clinical reasoning is a dynamic “weighing up” process over time towards planning appropriate actions

Sub Theme 1.1: The ingredients for the “weighing up” process

1.1.1 Multiple Factors

Categories	Nodes
1.1.1.1 Consider behaviour in premorbid history	<ul style="list-style-type: none">• Consider medical history• Consider effect of spiritual occupational engagement on balance of lifestyle
1.1.1.2 Consider here & now	<ul style="list-style-type: none">• comparison of current vs. premorbid level of functioning• behaviour atypical to client's usual self suspected to make symptom worse
1.1.1.3 Consider future plans	<ul style="list-style-type: none">• Clients' choice about future plan• Discussing future plans with client
1.1.1.4 Consider contradictions	<ul style="list-style-type: none">• Contradiction between clients & relevant norms• Contradiction between clients' behaviour & reasoning
1.1.1.5 Consider theoretical bigger picture	<ul style="list-style-type: none">• Consider functioning's appropriateness in relation to developmental stage

1.1.2 Observations

Categories	Nodes:
1.1.2.1 In and out of interactions in the wards	<ul style="list-style-type: none">• Observation in interaction
1.1.2.2 Over time for changing level of participation	<ul style="list-style-type: none">• Observation of change over time in interaction• Observation over time - level of participation

Sub theme 1.2 Actions

Categories	Nodes:
1.2 Action are taken to effect a behavioural change through education and negotiation	<ul style="list-style-type: none">• Psychoeducation for spiritual occupations in question• Explore alternative ways of being spiritual as a Rasta• Negotiating with clients about controlling the behaviours in question

Theme 2: Resources comes from different forms of information and knowledge

Sub theme 2.1: Collaterals

Categories	Nodes
------------	-------

2.1.1 Collaterals from within the team involved

- Collateral from cultural informants
- Colleagues as resource on spiritual and cultural beliefs
- Collateral from Team to determine the 'right time' to challenge
- OT colleague as a backup checking resource

2.1.2 Collateral from people who knew client before admission

- Collateral from next of kin
- Collateral from work about client's functioning at the time around admission
- ** Parents unrealistic collateral of clients' schooling history

Sub theme 2.2: Knowledge

2.2 Materials available electronically or in hard copies

- Resource - Google
- Textbook as resource

Sub theme 2.3: Rationale for using collateral & knowledge

2.3 Rationale for resource use

- research to better OT's own understanding

Theme 3: Experience, Attitudes and conflicts

Sub theme 3.1a: Unpleasant experiences for JOSE

Categories

Nodes

3.1.a.1 Unpleasant to be seen as an expert as JOSE does not feel she is one.

- Unpleasant when expected to be 'expert'
- OT's spirituality differ her clients in their contexts
- MDT expectation of OT as expert for her cultural background

3.1.a.2 Clinical reasoning is straight forward as most spiritual like behaviours are part of illnesses.

- Most spiritual like behaviours are of symptom natured

Sub theme 3.1b: Unpleasant experience for client

Categories

Nodes

3.1.b Knowing does not mean accepting.

- difficult to accept illness - even for the high functioning with medical background

Sub theme 3.2: Diverse attitudes about spirituality in psychiatry

Categories

Nodes

3.2.1 Biomedical view takes priority.

3.2.2 Client centeredness prompts desire of understanding & respect for clients despite reservation.

3.2.3 Ordinary people use spirituality as a mean of making sense of illness.

- Psychiatry - no go zone for traditional medicine
- Health professional views spiritual like expression or behaviour different to lay persons
- OT have reservation & respect for clients' reasoning
- OT not letting own background to influence her view on clients' behaviour
- I just wanted to understand (client's occ. engagement)
- Professional training teach client centeredness - used in viewing person in their context
- OT's view on why symptoms hide behind spirituality in psychiatry

Sub theme 3.3: Different conflicts arise when dealing with spirituality

Categories

3.3.1 Conflict in the Team and action to resolve it

3.3.2 Conflict between the team and family

3.3.3 Conflict between the team and the client

Nodes

- Conflict in MDT caused by clients' ability to 'cover up'
- Sorting out MDT conflict in WR using collateral from next of kin
- Conflict with family - them not as next of kin
- Conflict with family and MDT about how they perceive the 'problem'
- Tension between client & team in different view of the issue

* Words removed and replaced with similar ones for the protection of the participant's identity in some of Jose's quotes.

Appendix 6 c: Stake worksheet 3 for intra-case analysis of Siya

Stake (2006: p45): Adapted Worksheet 3 – Analyst's notes while reading a case report

Code letters for this case: Siya

Case study report title: Siya's experience of unable to deal with spirituality.

Analyst's Synopsis

The case: A 48 year old brown female occupational therapist of Islamic faith with 17 years of experience working with mental health. Siya worked in an admission unit, a step down facility and a neuroclinic.

The sites Siya describes scenarios in two settings she had worked at, i.e. female admissions and a neuroclinic. Siya is expected to run two weekly life skills group in the neuroclinic and be a case manager for allocated cases. For female admissions, she is responsible for the individual and group interventions with women inpatients.

The activity: Neuroclinic has a 6 weeks program for the maximum capacity of 12 individuals. Siya's main focus was being a case manager, run life skills groups and encourage leisure occupational engagements where possible in a program filled with groups by various professionals. Siya describes her clients as traumatized individuals who experience instability in their lives. This results in maladaptive personality and behavioural traits.

Spirituality is...

- Spirituality can be experienced through engaging in self reflection, doing good and learning with others.
- Spirituality is a motivating force for people to strive to be better and healthier.
- Spiritual occupations as seen in behaviours are neutral and possibly abstract on their own but health status influence its degree of contribution towards ill health or good health.

Siya was unable to identify any case for discussion regarding discernment of spiritual natured occupational engagements. After much prompting, she mentioned two cases involving sangoma's where she felt her clients were abused.

- Women seeking help from sangoma & got raped
- Psychiatric nurse breaking down
- Man seeking help from sangoma who robbed him

Key information sources Interview

Context information: The work setting at which Siya works is currently undergoing a lot of change which creates much uncertainty. This uncertainty comes through in the interview which may have contributed towards the difficulty that was experienced in inducing data in line with the research topic.

Even so, Siya provided some interesting view about spirituality and occupations.

E.g. despite staff seeks spirituality (in the form of religion) themselves; it is not an area of concern or priority in the treatment of clients.

Situational constraints:

- OT is not seen as an OT in the current environment of this neuroclinic. Siya is required to be a key worker as well (which means 'a bit of everything').
- Siya is observably affected by the uncertainty that is happening.
- Very strict rules in this neuroclinic – spirituality is definitely out and even recreational occupational engagement is not a priority. The focus in neuroclinic appears to be 'psychotherapy' groups.
- SIYA is in a part time post which means it is difficult for her to get involved with any ward programs outside of what she must see to due to lack of time.

Prominence of Objective 1 in this case: Low

Prominence of Objective 2 in this case: Low

Prominence of Objective 3 in this case: Low

Expected utility of this case for developing of themes towards Obj. 1: Low

Expected utility of this case for developing of themes towards Obj. 2: Low (Collateral from next of kin)

Expected utility of this case for developing of themes towards Obj. 3: Moderate (Barriers)

Possible excerpts for the multicase report:

- Working with spirituality is limited within the workplace despite it is meaningful to assist clients in self discovery due to what's required of the occupational therapist.
- Clients are notified about their behaviours that are seen to be inappropriate or contradicting.
- Collateral from significant others are important.
- Spirituality is not an area to be directly intervened. It is however a potentially positive and health giving experience to be have on your own with/within your higher being or shared with others through interactions in the ward.

Commentary <NB>:

- Siya spent most of the interview describing spirituality. She was anxious about her knowledge, hence the definition question was broken down much finer than for other participants.
- Siya was able to come up with 3 cases when prompted, however she stayed at a description level. It was difficult to explore the clinical reasoning behind, especially in relations to the fact that the team she worked in only spoke of the spiritual natured occupation as part of premorbid history.
- Interestingly, Siya differs with Imani's opinion about spiritual connection with others as she didn't think the shortness of the connection make it not spirituality.
- Siya has very interesting view on spirituality. She expressed that the occupation is neural in itself but it is clients' health status that made the occupations seem negative at times.

Intra-case analysis for Siya

Theme 1: Experience

Working with spirituality is limited within the workplace despite it is meaningful to assist clients in self discovery

Categories	Nodes
1.1 Negative	<ul style="list-style-type: none"> • experience of frustration in MDT
1.2 Barriers	<ul style="list-style-type: none"> • barriers for engaging clients
1.2.1 From clients	
1.2.2 From MDT outside and within neuroclinic	
1.3 Uncertainty	<ul style="list-style-type: none"> • SIYA unsure what religiosity really means although she suspect it is -ve for health
1.4 Positive	<ul style="list-style-type: none"> • Helping clients stimulates OT's spirituality

Theme 2: Importance of collateral

Categories	Nodes
Clients' significant others' input is important.	<ul style="list-style-type: none">• importance of next of kin's collateral

Theme 3: Providing feedback to clients

Clients are notified about their behaviours that are seen to be inappropriate or contradicting.

Categories	Nodes
3.1 About contradictions	<ul style="list-style-type: none">• pointing out contradicting behaviour to client
3.2 About inappropriateness	<ul style="list-style-type: none">• When clients have inappropriate behaviour, MDT call them in to W.R.

Appendix 6 d: Stake worksheet 3 for intra-case analysis of Sai

Stake (2006: P45): Adapted Worksheet 3 – Analyst's notes while reading a case report

Code letters for this case: Sai

Case study report title: Sai's experience in group context in exploring spirituality with clients through introspections.

Analyst's Synopsis

The case: 27 years **old female** occupational therapist with 2 years experience in mental health services (previously in an admissions unit and an adolescent unit). Sai self identifies as a reformed apostolic. **There was no indication of race on the consent form.**

Sai's outer experience in OT also includes working with students and in the community.

Sai's view on spirituality is...

- 1) Spirituality is belief systems (whether it involves higher being or not) that guide and motivate people to take particular ways of livings through e.g. motivational readings.
 - "Spirituality it's your belief system, it's [a] connection with what you believe in."
 - "For me, being spiritual is connecting with ... my religion [that] guides me. It's where I connect with my God..."
- 2) There is a fine line between health giving and symptomatic expression of spirituality as seen in clients' occupational engagement. Although it is not a common occasion, it is still important for OTs to explore with clients.

The sites: The work setting in which Sai works is divided into two wards where one has the capacity to stabilise 18 clients with psychosis (ward A). The OT focus there is engagement in basic occupations. The other ward's focus is on preparing for community reintegration. It has a capacity for 10 clients (ward B). Hence the focus in the 2nd ward is in life skills and prevocational placements where possible. There is a day patient unit to which clients can go to after discharge for 4 weeks. This unit is activity based and operated by OTAs and OT mostly under the management of a psychologist.

MDT overall interventions include looking for placements and family therapy sessions for parents of clients.

Sai mentioned that she had attended some in-service training sessions that different staff members had presented information about religion and cultural beliefs. She found these helpful when dealing with spirituality in her setting.

The activity

SAI is responsible for 2 inpatients wards in the adolescent unit, however she is based in the ward A with the more acute clients. She does not have an office at the “pre-discharge” ward (ward B). While the focus in ward A is for clients to engage in basic task orientated activities, ward B focus on life skills and goal setting towards community reintegration. For Sai, she highlighted the importance of enabling independence, and she put particular emphasis in independence in reflection and making future life choices.

Examples of the bigger OT intervention was shown in the interview as:

- Music therapy groups
- Behavioural modification through positive conditioning
- Art and craft activities
- The spirituality discussion group
- Life skills and goal setting

Sai spoke about a continuum of therapy intervention and hence the importance of “readiness” for different groups that has different demands on the participating clients. The direction of the continuum begins with concrete task orientated group sessions to the more discussion based groups. Therefore, it is implicit that she plays a role in finding the ‘right fit’ of activity demands to the current level of functioning of her clients by placing individuals in appropriate groups in different stages of their recoveries.

Sai had experience the clinical reasoning process with regards to spiritual natured occupations in the 3 following examples she gave during the interview:

- 17 yr old boy - working out sexual orientation
- Rasta boy with uncutted hair

- A group to discuss moral values where spirituality (reference to holy books as guideline) was induced

Key information sources Interview and observation when Sai took researcher around in the ward as an introduction before interview commenced.

Context information

Interestingly, researcher had observed some religious symbols around the ward where the interview occurred (e.g. the Jewish symbols) and Sai informed researcher that there is a preacher available to clients.

Situational constraints:

Specific to occupational therapy in the context:

- Lack resources (financial) and (academic literature on adolescent in occupational therapy). Hence, there is no standardized OT assessment.
- Individual clients need is not always met optimal by group sessions as some are more 'advance' in their recovery than others.

To the work context in general:

- Changing focuses of unit towards more acute and stabilization of psychosis as supposed to case management.
- Colleagues that OT worked with closely (on spirituality issues with clients) left and groups had stopped as a consequence.

Positive:

- Openness from the MDT allowed them to make exceptions to rules which enable clients' identity and spiritual searches (e.g. Rasta boy with big hair). However, the daily activities in the ward provided limited opportunities for spiritual occupational engagement (e.g. Christian prayer and free time where one client read the Bible at times).

Prominence of Objective 1 in this case (CR): high

Prominence of Objective 2 in this case (resource): moderate

Prominence of Objective 3 in this case (exp): high

Expected utility of this case for developing of themes towards Obj. 1: high

Expected utility of this case for developing of themes towards Obj. 2: moderate

Expected utility of this case for developing of themes towards Obj. 3: high

Possible excerpts for the multicase report:

1. When discerning about spiritual natured occupations, therapist need to take into behaviour observed, clients' readiness and their consistency and own reasoning to engage as well as its implication.
2. Different disciplines can team up together to work in a group setting. While the OT focuses more on the practical and component aspect of the group, psychologist can be the direction giver to facilitate clients' introspection. Spirituality with reference to lifestyle according to a belief system is induced through such group participations.
3. There are both opportunities and challenges in inducing spirituality in a group with a cross-disciplinary way. It allows appreciation of clients' developing insight and the ability of different professions while communications between professions can be challenging at times.
4. Dealing with spirituality in psychiatry is rewarding and mutually beneficial for both clients & therapist, however it can be hard emotionally.
5. One should have an attitude of openness, respect and humbleness to enable a space for discussions about their search for spiritual directions.
6. Limited resources: hence there is a strong reliance on what is available at ward level.
7. Efforts towards an open space to discuss spirituality are difficult to sustain as human resource availability is fragile.

Commentary <NB>:

- **MOST INTERESTING:** This MDT do not have an urgency in stopping potential inappropriate behaviours. It is respected which is different to adult settings. Such respect allowed professionals to be curiosity and explore clients' spiritual natured expressions which led them into spirituality.
- Sai view spirituality as her religion as her living guideline. This is obviously one of the four available connections. As 'narrow' as it may seem at first glance, this connection to higher being is also connected with self (introspection). It is amazing how it was applied in that psychology / OT joint group.
- Sai's self perception of 'don't know how to handle emotions' and subsequent team up with psychologist shows an interesting example of how 2 professions can work together towards on spirituality.
- Spirituality seems something that cannot be planned to get at directly but will be noticed or induced while in the action of therapy (congruent with other participants).
- Sai sees her clients as her resource and said so explicitly. It appears humbling as she shares part of herself with them. The therapist's power position is pull towards equality with clients in this incidence.

Intra-case analysis for Sai

Theme 1: Clinical reasoning

A process to consider therapist's observation and assessment and clients' own perspective to take appropriate actions.

Sub theme 1.1: Observation

Categories	Nodes
1.1.1 In groups - Observe for symptoms, behaviours and interaction in groups and their appropriateness across time.	<ul style="list-style-type: none">• Observation of functioning through monitoring components• Observe appropriateness or realistic-ness of conversations• Observe behaviour & address client about it• Observe behavioural change to assess 'right time'• Observe how client interact with OT• Look for symptoms in group participation
1.1.2 In ward - Behaviours pointing towards illness vs. healthy	<ul style="list-style-type: none">• Inconsistency of expressed beliefs and behaviour point towards illness• Client's ability to apply self identified resource towards finding an answer for their own questions = not psychosis

Sub theme 1.2: Multiple considerations - Readiness, consistency & duration, seriousness of the change.

Categories	Nodes
1.2.1 Readiness	<ul style="list-style-type: none">• Clients readiness to engage evaluated against presenting behaviours
1.2.2 Consistency & duration	<ul style="list-style-type: none">• Consider consistency and duration of the expressed idea• Consider consistency of issue expression while client with diff MDT members
1.2.3 Seriousness of the impact of change	<ul style="list-style-type: none">• Consider the seriousness of the change the teen wanted

Sub theme 1.3: Clients' own perspective

Categories	Nodes
1.3 Clients' insight	<ul style="list-style-type: none">• Client use holy books as guideline for ways of living• Clients' interest in religious scriptures only became an issue when settled• Clients own process of introspection

**Sub theme 2: Action
Categories**

2.1 Taken by the MDT

2.2 Introspection/spirituality group by OT & psychologist

2.2.1 Starting up

2.2.2 In action

2.2.3 Experiences from this group

2.2.3.1 Opportunities

2.2.3.2 Challenges

Nodes

- contradiction to collateral confirmed previous behaviours

- MDT discussion precedes action collectively decided towards clients
- Acknowledge the conflict client is going through with their life experience

- setting up 'the group'
- Rationale of having the spiritual group
- Own curiosity (with psy) needing to confirm if clients were really 'just psychotic' as said by other MDTs

- Roles of diff. profession in the spirituality gp
- Guiding clients in introspection in spirituality grp

- Evaluate clients' level of insight through their participation in sp grp
- 2 profession working together & appreciate each other as partners

- Challenges with 2 professions facilitating together
- although objective of spirituality was clear, there was no clear language to name the gp

**Theme 2: Resource & Barriers
Lacking literature hence reliance on people & environment**

Categories

2.1 Resource

2.1.1 Environmental resource for client

Nodes

- ward enviro diff from home enables self exploration
- Being ill and participating in groups allows lots of time to think and question

- Ward structure helping client to settle
- Contradictions may exist between clients hx and now - NB to check with family

2.1.2 People resource for client

2.1.3 Resource for OT

- Colleague (Psy partner in gp) as emotional resource
- Client as resource for OT
- Case management stimulated communication between MDTs - which led to starting of the gp about spirituality

2.2 Barriers

2.2.1 Physical barriers

- Physically not being in the ward as a barrier to restart the sp group
- OT unable to follow up as she didn't work in where clients transfer to

2.2.2 Systematic barriers

- changing focus of the wards creates pressure
- No space for deeper therapy while group is mixed with more psychotic clients

2.2.3 Political barriers

- No space for other connections of spirituality besides the grp
- No time or space to introspect because the issue client experience is unspeakable
- No time to do more in depth intervention

- group about spirituality collapsed when psy resigned

2.2.4 Human resource barriers

2.2.5 Lack of literature

- Lack of literature with a focus on adolescents
- didn't use Internet as new things occur daily

Theme 3: Experience & Attitudes

Sub Theme 3.1: Experience

Categories

3.1 Mutually influential

3.2 Feeling responsible

3.3 Feeling empathic

3.4 Feeling emotionally stressed

Nodes

- introspection induced emotional and satisfaction in seeing clients' progress
- guiding clients in introspection also trigger it in OT & psy
- OT felt unable to deal with clients feelings - recruitment of psy as a strategy
- OT felt the ethical responsibility to respond to sensitive info client gave her
- It is tough being a teen with mental illness
- Clients stories evoke emotions in OT
- Difficulty in being professional and not bringing in your own stories
- Client entrust OT with their traumatic experience of which OT found difficult to deal with
- Because teen change all the time as they finding who they are - discernment is difficult

Sub Theme 3.2: Attitudes – openness & give space

Categories

3.2.1 OT

3.2.1.1 Be respectful

3.2.1.2 Be humble

Nodes

- respect for others with different way to spirituality
- respect the spiritual but not religious but there is uncomfortableness about them
- Need to respect spirituality even if clients r psychotic
- Don't want to impose on clients' family values
- OT acknowledging MDT effort in achieving the 'turning point' for clients' recovery
- Be honest and share yourself
- Allowing space for independence was more important than having an answer

3.2.2 MDT

- MDT's allowance of space for clients to explore religion or beliefs
- MDT's openness and respect for clients

University of Cape Town

Appendix 6 e: Stake worksheet 3 for intra-case analysis of Kris

Stake (2006: p45): Adapted Worksheet 3 – Analyst's notes while reading a case report

Code letters for this case: Kris

Case study report title: Kris's experience on dealing with occupations of spiritual natured engaged in by her clients in her current clinical practice.

Analyst's Synopsis

The case: KRIS is a 37 year old female occupational therapist who has 13 years of experience in forensic psychiatry. There was no indication of race or religion on Kris' completed consent form.

Kris's view on spirituality is...

- Health giving spirituality is positive if enhance other occupational engagement, trigger positive memories despite possible linkage with psychosis
- Symptomatic spiritual natured occupations are not spirituality
- Spirituality is not religion but it seems to be the dominant way

Kris had dealt with discerning about spiritual natured occupations in the following cases as discussed in the interview

- Client's positive occupational engagement in religious activities (client with 2 religions & extremely religious Islamic client) or as part of their 'normal everyday' occupations such as employment (Gardener).
- Clients' negative occupational engagement in religious activities as part of their illnesses.
 - Client inconsistent religious views vs. workers getting 'signs' at work.
- Through realising its occurrence in activities within her program that other facilitators run (i.e. yoga and pottery).
- Nature as an enabler for stimulating spirituality for the 'here and now' and trigger positive past.

The sites: The workplace (unit) of Kris consist of four wards. She is directly in charge with a ward with more stable forensic clients while another therapist and an OT assistant looks after the other three. The total capacity of the forensic unit is 145 across the four wards.

- 1) Institutional domination by Christianity despite diversity exist

- 2) Practical barriers to engage in chosen spiritual occupation (i.e. medication must be taken hence Muslim clients cannot fast)

The activity

Observations, supported employment and ward activities in groups and individuals.

- 1) Social events and outings during evenings and weekends.
- 2) OT wants to address the issue of balanced lifestyle despite positive spiritual meaning is found in client's productive occupation.

Kris stressed the importance to start looking at 'what is meaningful' to the client. And if it is about spirituality that is meaningful, then it would be subconscious for OT to look into clients' spiritual natured occupations. However if the meaning is of psychotic nature then it should be avoided and not engaged with.

Key information sources Interview with Kris and her timetable

Context information

- MDT Rx: home visit, supporting staff supervising activity groups and monitoring medication
- Level of hesitation to discuss religion as a potential dominant channel to spirituality. Kris attributes her hesitation to the possible coexistence between psychosis and spiritual occupational engagement of a religious nature.

Situational constraints:

- Forensics: the nature of admission means less choice and freedom for clients in terms of their associations and movements.
- General atmosphere in MDT is to stay clear of spirituality as they see it as a direct link with religion and hence symptomology. In contrast, KRIS believes that such atmosphere do not affect the OT intervention.

Prominence of Objective 1 in this case (CR): Moderate/Low

Prominence of Objective 2 in this case (resource): Low (employer and volunteers/ activity facilitators as resource)

Prominence of Objective 3 in this case (exp): High (OT spiritual people not spiritual profession)

Expected utility of this case for developing of themes towards Obj. 1: Moderate/Low

Expected utility of this case for developing of themes towards Obj. 2: Moderate/Low

Expected utility of this case for developing of themes towards Obj. 3: High

Possible excerpts for the multicase report:

- Hesitance about spirituality in psychiatry can lead to avoiding, ignoring or taking action on it.
- Resources outside of MDT are identified as helpful.
- When making discernment about spiritual occupations, take clients' perspective on meaningfulness and implication of engagement into account despite it may appear contradicting to MDT.

Commentary <NB>:

- Kris experience discernment about spiritual occupations as challenging but only positive (as symptomatic does not count).
- Interesting comment by Kris at the end of the interview about occupational therapists as spiritual people but not necessarily as professionals. In the sense that 'spirituality' had never been on the agenda, it had remained the unspoken yet important part of the profession.
- Contradictions:
 - Pastor (Christian service) and mealtime Christian prayer allowed in workplace while there is a so-called 'avoidance' policy on religion.
 - What MDT think 'does not influence' OT program yet Kris also have parallel hesitation about engaging with spirituality
- People (or environment external to the hospital) seem to stimulate spiritual occupational engagement more – they seem a better resource to the clients.
- Actions: actions and initiatives are taken at micro level within occupational therapy program to accommodate diverse spirituality.

Reference

Workplace of Kris (2010). On Wikipedia, Accessed online, [2010-05-01].

(Note: name of workplace removed due to confidentiality)

Intra-case analysis for Kris

Theme 1: Clinical Reasoning

Consider clients' perspective and implications for engagement

Sub theme 1.1: Consider possible risks and implications

Category	Codes
1.1.1 Warning signs	<ul style="list-style-type: none">• Better to stay away from spiritual dimension if feeds into delusions• Change in religious belief as an indicator of psychosis
1.1.2 Potential risks	<ul style="list-style-type: none">• Concerns arise when client re-enter context in which he had delusions• connection with religion changing client's occ pattern
1.1.3 Implication of engagements	<ul style="list-style-type: none">• When clients unable to do basic interaction& participations - religious expression have -ve impact• If religiosity lead to unbalanced actions & attitude = +ve symptoms

Sub theme 1.2 Consider clients' perspectives

Category	Codes
1.2.1 Clients' factors	<ul style="list-style-type: none">• Clients beliefs deduced to be psychotic nature and not religious• Uncovering a good fit with time• Weighing up experience & interest• Take clients' perspective on source of meaning - spirituality is not always where meaning lies

Sub theme 1.3 Different degree of facilitation from OT for spiritual natured occupations

Category	Codes
1.3.1 Facilitation directed by OT	
1.3.1.1 Now	<ul style="list-style-type: none">• acting against institutional symptom of Christianity - respecting diversity in OT groups

- Action regarding spirituality OT had done
- Discussion with OT colleagues in same system about bring in diversity in religion
- client centred individual discussion about fasting
- Future plans - increase diverse accessible religious choices

1.3.1.2 Future

1.3.2 Facilitation through OT indirectly

1.3.2.1 supervised facilitators and volunteers

- recreational activities can be more than occupations but windows to spirituality as well dependent on facilitator

1.3.2.2 assisting MDT

- Admitting client from home but cont occ eng after observing concern
- team decision on sick leave for a client
- MDT adjusting medication to 'make it work' for fasting clients

Theme 2: Resources

Outside the workplace

Category

Codes

2.1 Non-human

2.1.1 Academic materials

- Becoming more aware about spirituality in OT while doing MSc (OT)

2.1.2 Time

- Monitor client over time uncovers shift of delusions

2.2 People

2.2.1 From the workplaces where clients are supportedly employed

- Client & their boss's matched spiritual connection to their work create good

	environment for occ performance
2.2.2 Clients' family	<ul style="list-style-type: none"> • Co-workers (boss) who can offer opportunities for spirituality for client that OT felt she cant provide • Influence in supported employment workplaces stimulate spiritual experience for clients • Supervisor at work leading a collective spiritual occupation as routine part of where clients work
2.2.3 People outside the MDT in the hospital	<ul style="list-style-type: none"> • collateral from primary carer helps • Volunteers & activity facilitators as resource that can offer opportunity towards spirituality while interacting with clients

Theme 3: experience, opinions and attitudes

Sub theme 3.1: Mixed Experience

Category	Codes
3.1.1 Challenging	<ul style="list-style-type: none"> • Fine line between spirituality & psychosis concerns OT • I don't have a program designed around spirituality
3.1.2 Hesitation	<ul style="list-style-type: none"> • It is the context of psychiatry that makes OT hesitate to encourage spiritual occ
3.1.3 Only positive, negative doesn't count	<ul style="list-style-type: none"> • discernment about sp occ has been +ve as it allows OT to understand clients • Working with spirituality is a subconscious reaction for OT if what clients find meaningful is spiritual • Seeing symptomatic sp is not sp so no -ve experience • OT stuck by others approach to spirituality

- and found it positive
- Religiosity is common denominator in acute psychosis
- seriousness of spirituality suggests meaning but not enjoyment

Sub theme 3.2: Opinions

Category	Codes
3.2 Opinions	<ul style="list-style-type: none"> • OT are spiritual individuals yet not professionals - not bring it into our program • The significance of unspokenness about spirituality in OT profession

Sub theme 3.3: Attitudes

Category	Codes
3.3.1 It's all bad, says MDT.	<ul style="list-style-type: none"> • Anticipation of religious consciousness as a +ve symptom in psychiatry • Hesitancy from psychiatrists to include spirituality in program • Psychiatrist try to establish exclusion of religious activities
3.3.2 Client's perspective has a say, says OT.	<ul style="list-style-type: none"> • clients' perspective on meaning out weight MDT confusion and politics on spirituality - does not affect what OT do (?also CR) • Even through respect for diverse religion is not clients' priority it's still not 'right' to allow domination

3.3.3 Contradictions

- OT see meaning & occ engagement vs. MDT see psychosis
- Contradicting message - not to include spirituality as religion yet have a pastor coming in

University of Cape Town

Appendix 7: Stake worksheet 4 for ratings of expected utility of each case for each objective

Stake (2006: p49): Worksheet no. 4 – Ratings of expected utility of each case for each objective

	Imani		Jose		Siya		Sai		Kris	
Original obj's	U	P	U	P	U	P	U	P	U	P
Elements of clinical reasoning	High	High	High	Mod	Low	Low	High	High	Mod	Low
Helpful Resources used	High	High	Mod	Mod	Low	Low	Mod	Mod	Mod	Low?
Experience of the discerning process	Mod	Mod	Low	Low	Low	Low	High	High	High	High
Added categories										
Context matters	High with P3 (temporally)		High		High with P1 (temporally)		High		High	
Availability and usage of resource	Moderate		Low		Low		High		High	
OTs' Attitudes about working with spirituality	High		Low		Low		Moderate		High	
Clients contributions	Moderate High		Low		Low		Moderate		High	
Note: Rate each box with - High importance for development towards research objectives / added themes = H, middle = M & Low = L. This is very NB step; please repeat with fresh mind one more time after initial rating!!										

Appendix 8: Stake worksheet 5 A for matrix for generating theme-based assertion

Stake (2006: p51): Worksheet 5A. Matrix for generating theme-based assertions from findings rated important (Very NB: 3; Moderate: 2; Note NB: 1)

1: Clinical reasoning; 2: Resources; 3: Experience; 4: Context matters; 5: OT attitude; 6: Client contributions

	Objectives & added themes						
Imani:	1 C R	2 R E	3 E X	4 C M	5 O A	6 C C	
Finding I: Clinical reasoning about spiritual occupations is complexes, dynamic and multi-layered which often begin with curiosity and desire to understand clients' behavior.	3 *	1	1	3	1	1	
Finding II: There are two components to the discernment: a) is this a spiritual occupational engagement? and b) is it a health giving or a symptomatic spirituality?.	3	1	1	2	1	1	
Finding III: When discerning, look for the meaning of the occupations, the appropriateness and consistency in the time and context in which it occurs. The action taken post-discernment is further influenced by considering the benefits and harm for the individual and the population in the ward.	3 a	1	1	3	1	1	
Finding IV: Resources come in the form of people – the clients and OT themselves, other team members as well as external organizations.	1	3	1	3	1	3	
Finding V: The experience of such discernment is enriching as it acknowledges existing diversity in the team and better understanding of the clients. However, it becomes uncomfortable when one is expected to know as an expert when it is assumed that similar origin between staff and clients will provides answers towards questions of such	1	1	3 *	3	1	3	

discernment.								
Finding VI: Reliance on one's own intuition ('gut') is also a helpful strategy.	3	2	1	1	3 *	1		
Jose:	1	2	3	4	5	6		
Finding I: Clinical reasoning is a dynamic "weighing up" process over time aided by observation to consider multiple factors– history, here & now, future plans, contradictions and theoretical bigger picture	3	1	1	3	1	2		
Finding II: Action are taken to understand the nature of the behaviour and then to effect a behavioural change through education and negotiation at the 'right time'.	1	3 *	1	3	1	1		
Finding III: Multiple sources of knowledge are used in the discerning process, including collateral, academic literatures and information from the internet. The preference of knowledge/information is in the order of : 1) within the team or from people who knew client before admission, 2) online and 3) OTs outside of the team.	3	1	1	3	2	1		
Finding IV: It is unpleasant to be seen as an expert because P2 does not think she's an expert in her culture.	1	1	3	3	1	1		
Finding V: Discernments about spirituality is experienced to be straight forward due to its likelihood towards being a symptom.	1	1	3	3	3	1		
Finding VI: Tension exist between biomedicine perceiving itself as dominant and therefore rightfully takes priority while OT philosophy requires OTs to take clients' perspective into account even when spiritual occupations were deemed to be part of symptoms.	3	1	3	3	3 *	2		
Finding VII: The differing view about the nature of spiritual behaviours observed by team, OT, clients and their families/next of kins causes conflicts amongst stakeholders.	1	1	2	1	1	1		

Siya:	1	2	3	4	5	6		
Finding I: Working with spirituality is limited within the workplace despite it is meaningful to assist clients in self discovery	1	1	3 a	3	2 *	1		
Finding II: Clients are notified about their behaviours that are seen to be inappropriate or contradicting.	1	1	1	3	1	2 a		
Finding III: Collateral from significant others is important.	1	3	1	1	1	1		
Finding IV: Spirituality is not an area to be intervened but is a potentially positive and health giving experience to be have on your own with/within your higher being or shared with others (fellow patients and staff in neuroclinic) through interactions.	1	1	2	3	3	1		
Sai:	1	2	3	4	5	6		
Finding I: When discerning about spiritual natured occupations, therapist need to take into account observations in the groups and ward, clients' readiness and consistency to engage as well as how long & serious is the engagement and weight this against clients' own perspective on their engagement.	3	1	1	3	1	2		
Finding II: Different disciplines can team up together to work in a group setting. While the OT focuses more on the practical and component aspect of the group, psychologist can be the direction giver to facilitate clients' introspection about their past, present and future. Spirituality with reference to lifestyle according to a belief system is induced through such group participations.	1	2	2	3	1	2		
Finding III: There are both opportunities and challenges in inducing spirituality in a group with a cross-disciplinary way. It allows appreciation of clients' developing insight and the ability of different professions while communications between professions and having language for such a group is not optimal at times.	1	1	3 *	2	1	1		
Finding IV: Dealing with spirituality in psychiatry is rewarding and mutually beneficial for both clients & therapist, however	1	3	3	3	2	1		

it can be hard emotionally.		a	*					
Finding V: One should have an attitude of openness, respect and humbleness when approaching spirituality with clients to enable a space for such discussions.	2	1	2	1	3 *	1		
Finding VI: Limited resources are available about adolescences and spirituality; hence there is a strong reliance on what is available at ward level.	1	3	1	3	1	1		
Finding VII: Efforts towards an open space to discuss spirituality is difficult to sustain as human resource availability is fragile and that macro influence may want professions to work more in the reductionistic biomedicine paradigm which is not conducive for the inclusion of spirituality in psychiatry.	1	1	1	2	2	1		
Kris:	1	2	3	4	5	6		
Finding I: Conflict about avoiding, ignoring or taking action about spirituality exist.	1	1	2	2	2	1		
Finding II: Resources outside of MDT are identified as helpful.	1	3	1	3	1	1		
Finding III: When making a discernment about spiritual occupations, take clients' perspective on meaningfulness and implication of engagement into account despite it may appear contradicting to MDT. (Note: client centeredness regardless spirituality or not)	3 a	1	1	3	3	3 *		

Note: Rate each box with - High importance for development towards research objectives / added themes = H, middle = M & Low = L.

- Parentheses around theme number means that it should carry extra weight in drafting assertion. Notation "... (atypical)" after a case means that its situation might warrant extra caution in drafting assertion.

Appendix 9: Stake worksheet 6 for multi-case assertions for the final report

Stake (2006): Worksheet 6. Multicase Assertions for the Final Report (adapted)

BYP = assertion by bypass ; CCA = cross case assertions.

Designator BYP vs. CCA	Assertions	Related to objective / added themes?	Evidence, persuasions, reference in which case?
<u>BYP 1-1</u>	Clinical Reasoning: complex, dynamic and multi-layered	Clinical reasoning process [1]	<p>Category 1: Client centeredness precedes other considerations</p> <ul style="list-style-type: none"> Tension between biomedicine and OT philosophy <i>"Yar he's currently still there and he's been there for about 2 years now. yar very stable umm interesting actually, I would say stable and okay. But he came to visit us in the ward round the other day, he was sitting in a multidisciplinary team and he's started talking about his connections and the powers how he get messages from certain plants. And then the whole team was discussing that he was clearly psychotic.... And it is true, there is.. he is thought disordered and psychotic but at the same time I could see that it was meaningful..." [Kris]</i> Meaningfulness & implication for engagement <i>"Umm so I take each person's meaning and experience of meaning... and then some will have spiritual implication and I will draw on it from there." [KRIS]</i> Curiosity <i>"people were just curious cos' ... what is he saying cos'... he's not saying hello..." [IMANI]</i> Desire to understand client <i>"the first thing that was done by the MDT to say that, u know, to understand why it is that they need to wear the full keejap..." [IMANI].</i>

			<p><i>The Twasa thing, [I was looking for] being a spiritual sangoma. The Rastafarian I just wanted to understand it. [JOSE]</i></p> <p><i>why they do what they do because obviously they don't do what we do. We have a lot of the patients with the long nails and refuse to cut it and big hair umm they needed to do drads and you know they were dirty so I needed to understand why ...[JOSE]</i></p> <ul style="list-style-type: none"> Respect and openness <p><i>"we need respect for that even through we dealing with psychotic clients here, we still need to consider that that is still part of that person's life." [SAI]</i></p> <p><i>"you also need to have a healthy <u>respect</u> for how people practice what they do"[Imani]</i></p> <p><i>"The only way we found we could get more things out of them is you come up with your scenarios you be honest, you share." [SAI]</i></p> Client voice matters <p><i>"...I don't think that it was linked to psychosis solely, I also think that because of his spirituality and then he knew that the Bible was a guideline for him and he started questioning, for example the 10 commandants say you are not supposed to and so he's questioning so why am I?" [SAI]</i></p> <p><i>"... for me when we working with a group of people or people on individual basis where do they find the most meaning?" [KRIS]</i></p> <p><i>"...he was sitting in a multidisciplinary team and he's started talking about his connections and the powers how he get messages from certain plants. And then the whole team was discussing that he was clearly psychotic.... And it is true, there is.. he is thought disordered and psychotic but at the same time I could see that it was meaningful [KRIS]</i></p> <p><i>"I look at the person and look at their context which is how I think we are taught to look at before..." hence, "...I don't come with I am Hindu and this is how I think." [JOSE]</i></p>
--	--	--	--

			<p>Category 2: Complex weighing up process</p> <ul style="list-style-type: none"> Observation <p><i>“He [was] not really engaging in the activities in the group but he would stand to one side or sit quiet[ly] sometimes ... [or] when he’s not sitting quietly and engage in the hand movement and whatever he says.”[IMANI]</i></p> <p><i>“I notice with the time ... slowly the face covering disappear As perhaps when they become more familiar with the set up and feel more secure to let those things go...” [IMANI]</i></p> <p><i>“as you observe people in their practice, if they are consistent... .. it is more likely to be true to what they would do in a healthy state but it is that inconsistency , u know, that lead you to question whether the expression of spirituality is an expression of ... or whether the behaviour is a expression of true spirituality or whether is part of a psychosis ...” [IMANI].</i></p> <p><i>“we saw her taking to herself and she was saying ... how beautiful and energetic she is and the world cup comes around Cape Town is going to be so flifty that she’s going to go around cleaning Cape Town things like that.”[JOSE]</i></p> <p><i>“when everyone say she’s stable she’s not talking too much, energy level lower and I [also] saw how she engage in the group [and] one on one, with good eye contact and made a lot of sense.”[JOSE]</i></p> <p><i>“But in the groups, he was able to engage, he was able to follow instructions, ... able to complete tasks [and] concentration was good. There was no time I could really observe him being psychotic.” [SAI]</i></p> Appropriateness & consistency <p><i>“...a women does dress up in full keejap <u>but</u> she still does not <u>act</u> modestly that this</i></p>
--	--	--	---

			<p><i>dress is suppose to imply then there's something else going on."</i> [IMANI]</p> <p><i>"...because in OT, ...and it didn't only happen there when you asked about the Bible we spoke about. It also happened in psychology also."</i> [SAI]</p> <p><i>"I mean there is <u>consistency</u> and there is <u>appropriateness</u>... yes his behaviour is consistent but it is not appropriate ... one needs to take the two into... <u>it goes hand in hand</u> ..."</i> [IMANI]</p> <p><i>"But in the groups, he was able to engage, he was able to follow instructions, ... able to complete tasks [and] concentration was good. There was no time I could really observe him being psychotic."</i> [SAI]</p> <p><i>"...but it's not a Hindu name, ... people at the temple don't give you names anyways, your parents give you names."</i> [JOSE]</p> <p><i>"it all sounds delusional because like the women with the outside water only, it all comes from the same source so it wasn't bore hole water, it [the tap] was just outside."</i> [JOSE]</p> <ul style="list-style-type: none"> Weighing against clients' own perspective <p><i>"We have a lot of the patients with the long nails and refuse to cut it and big hair umm they needed to do drads ...so I needed to understand why ..."</i> [JOSE]</p> <p><i>"what would be their description of meaning be? Cos' some people it would have a spiritual dimension but for others it would be have a very concrete dimension like poverty alleviation. Umm so I take each person's meaning and experience of meaning... and then some will have spiritual implication and I will draw on it from there."</i> [KRIS]</p> Person's narrative against norms <p><i>"[I also look at] how were they coping and like ever since they used gunja what happened and like basically how they stay their day, I look at if it's more balanced or not."</i> [JOSE]</p> <p><i>"I look at how the person is now and...what they were doing before."</i> [JOSE]</p>
--	--	--	---

			<p><i>"So we said [to her] what is the story now? Are you going to carry on with the process? Yes. Are you going to go back to work? No." [JOSE]</i></p> <p><i>"Does gunja make them zone out so much that they have to sleep the whole day and they are 20 years old and they could work ..." [JOSE]</i></p> <ul style="list-style-type: none"> Benefit & harm <p><i>"he was there to seek help ... not necessary to provide a service ... would it be right for him to be providing that service [minster counselling]?" [Imani]</i></p> <p><i>"It [the full keejap] creates a barrier of communication .. part of being in the mileu is the improve communication." [IMANI]</i></p> <p><i>"but changing in terms of music and clothing is a different part to changing like Shane* being gay or something.." [SAI]</i></p> <p><i>"...when I seen people very psychotic to such a degree that they find it hard to participate in a conversation or an activity for a long time and if their symptoms are religious based, then yes it's almost always a negative impact....that's very close to be out of touch with reality and close to the psychosis." [KRIS]</i></p> <p><i>"for example he prays five times a day, that means he gets up early in the morning and he goes to mosque and spend some time there [A: everyday?] yar everyday. And he also goes to classes everyday where he's learning again. He's also started travelling with a group of people who go and pray at different area of mosque. So all his occupations are changed." [KRIS]</i></p> <p><i>"He doesn't interact in society outside where it would be seen as very odd so it seen as more acceptable..."[IMANI]</i></p>
--	--	--	--

			<p>Category 3: Critical check points</p> <ul style="list-style-type: none"> Is it a spiritual occupation? <i>"[I] doesn't know whether that it's something he (staff) picked up from his (client) original background.. or whether it is something developed later on as a perhaps Autistic tendency to engage in repetitive behaviour so ... is it spirituality?" [IMANI]</i> Is it health giving? Is it a symptom? <i>"it goes hand in hand to decide whether the behaviour is appropriate or whether it is suitable spiritual ... not suitable (softer) spiritual ... but Whether it is a spiritual expression that could indicate a psychiatric illness or whether it is just their ways of expressing themselves." [IMANI – jointed for both above]</i> Is client ready to engage? <i>"[When] he was admitted, he was really psychotic, disorganized speech, he couldn't really engage in a conversation. He would talk about blue he would talk about black ... he need to be stabilized before he can engage in an activity...". [SAI].</i> What does my gut says? <i>"my whole philosophy if it works for you and it's working for the people around you and/or it's not interfering with the people around you then it's okay" [IMANI]</i> <p>Category 4: Context matters</p> <ul style="list-style-type: none"> Limited resources for adolescent psychiatry <i>"...for adolescents it is quite different to find articles specific to what you specifically dealing with in the group. There are no books and I think the same they learn from one another the same we learn from one another." [SAI]</i> Straight forward symptoms <i>"Most of it [the spiritual natured behaviours or expressions] was part of the illnesses and not health seeking." [JOSE]</i> <i>"luckily most of the patients comes with the basics ... you are relatively covered. So ok that's normal, that's not so normal and I am not so sure about that..." [IMANI]</i>
--	--	--	---

			<p>"has there been a negative experience? Umm ... well u see then I would not classify it as spirituality if I am talking about someone who is completely psychotic and religieuse." [KRIS]</p> <ul style="list-style-type: none"> Frustrated by limitation on OT scope within program <i>"But now they look at me and I mismanage this patient. This is the first I hear of this and nobody had said anything before."</i> [SIYA – frustration when one is not acknowledged/allowed to be an OT] Preference for team as resources <i>"I use them [OT colleagues] to ... if I feel that I am not entirely satisfied with the answer that I got here."</i> [JOSE] Environment: the ward, workplace and nature <i>"...it gave him more time ...to think cos' he got well [when] it was in a stage where we wasn't [an] acute psychotic unit. So we did rehab things and he got well and then he started questioning ..."</i> [SAI] <p><i>Now, the person he works with, he's also very much a spiritual person umm and he's extremely in touch with nature and getting energy from nature. So the relationship between the two of them are dynamic, because they just clicked. Umm they get the energy leve.</i> [KRIS]</p> <p><i>there is one lady who's very much encourage religious, like before they start their day everyone gets together they stand in a circle, somebody says a prayer, it can be anybody any kind of prayer. It can be an Islamic faith or if you are from a Christianity base. Somebody will pray in the group before they start their day. And for her, it is a positive motivation to get everybody ready for the day, a very peaceful frame of mind.</i> [KRIS]</p> <p><i>" ... one day we went and spend 5-6 hours at Kirstenbosch and somebody took us through a walk at Kirstenbosch ... and afterwards we came back we sat on the lawn and we had a group umm and it's just peaceful and quiet, the view is fantastic and everyone was</i></p>
--	--	--	---

			<p><i>peaceful in touch with nature and trigger a lot of previous memory of them being in touch with nature and all of those memory were positive.” [KRIS]</i></p> <p><i>“like when we go to the beach, for a lot of our clients; the sea water have some kind of significance.”[KRIS]</i></p> <ul style="list-style-type: none"> Implication of clients’ engagement for the wardenvironment <i>“...in order to <u>protect</u> the system that expression of [Rastafarian] their spirituality or religious belief ... would be religious practice would be ‘catail’.” [IMANI]</i> <p><i>“It is very debatable whether cannabis is good thing or bad thing for one’s mental state ... if [it is] good for you when you doing it in the ward ... someone else who it may be bad for may be encouraged by what you do...”[IMANI]</i></p> <ul style="list-style-type: none"> Rules in the ward <i>“I would say not usually not allowed, just part of the ward rules that [when one] just come in, like music centre, whether it’s a Bible or book it must be handed it in. “ [SAI].</i> <p><i>“As a rule, from what I have seen with the patients who are grandiose whether it is Christian or Muslim or whatever; we.. when we have a group, we stay away from the religious because once it starts it goes on and on and on...” [JOSE]</i></p> <p><i>“it’s known that when you come into the program there is certain expectation and you buy into that.” [IMANI]</i></p> <p><i>“...the rule is there to stop us from fighting about who’s right and who’s wrong and who’s beliefs are .. superior or take presidency in the situation... because in the ward, the ward rules presides.” [IMANI]</i></p> <p><i>“...to a certain extend the wards rules of confidentiality helps to protect one within that relationship and you also know that in most cases you wouldn’t see this person again....”</i></p>
--	--	--	--

			[IMANI]
<u>BYP 2-2</u>	Multiple sources: people as key	Resources [2]	<p>Category 1: People</p> <ul style="list-style-type: none"> The occupational therapist “I think ...it’s also where I come from and what my life experience is umm... that’s hopefully had made me a little more open minded...about spirituality” [IMANI] <p>“when everyone say she’s stable she’s not talking too much, energy level lower and I saw how she engage in the group [and] one on one, with good eye contact and made a lot of sense.” [JOSE]</p> <p>“we went back [to] him after two weeks, back to work and he’s working fine and everything is okay but now he shifted his his his umm delusions onto his home environment ...which now has implication for...is he going to harm his mum cos’ he lives with her.” [KRIS]</p> <p>“I am not sure about models, what works works.” [IMANI]</p> <ul style="list-style-type: none"> Clients “Because it is sometimes it is a belief that ... it is not necessarily the fact ... is it really the way things should be [and] go back to ... why you (clients) think this is the way things should be?” [IMANI] <p>“The patients at the end of the day became my resources.” [SAI]</p> <ul style="list-style-type: none"> Team members “it depends on the background they come with and what cultural background they come with... whom we are going to draw on most.” [IMANI] <p>“we spoke to our Xhosa women around here and whoever we could speak to here about it and they told us no they do go through rituals but ...and they compare what her behaviours to what she was doing what she was saying and they say no this is not right...”. [JOSE]</p>

			<p>“The fact that [psychologist] was there, we spoke about it; sometime I was emotional I had to vent and same with her. So we became resource for each other.” [SAI]</p> <ul style="list-style-type: none"> Collateral from significant others <p>“we also got collateral from the boyfriend [next of kin] ... he said she’s not sleeping we saw her talking to herself she ‘s acting strangely at work.” [JOSE]</p> <p>“we don’t know but the wife actually need to confirm this...” [SIYA]</p> <p>“...but when the parents came and confirm and said that he is but it’s not dagga it’s belonging to them [Rastafarian]” [SAI]</p> <p>“But the way the result in the interview with his mother, ...she said she supervises his medication so he’s been definitely taking it. So that kind of factor that we think okay that’s he’s compliant. And we can’t think of anything from the interview with him with his mum what significant stresses. Because things were going really well at home and at work.” [KRIS]</p> Volunteers and facilitators <p>“I have also seen some of our volunteers in our group work, u know what they bring as a person. As you know we have the pottery going and I have seen it in our yoga class. That as individual people, they are extremely spiritual in their own way umm the one draws on energy source and the other one draws on meditation and that captures the attention of our clients and they have discussions around it and they talk about it and I found that it is more than just doing the pottery then and it’s more than just doing the yoga activity.” [KRIS]</p> Employers <p>“Her line manager was also a Xhosa male and she gave him a hard time because she said you are a black man, you understand you understand the culture. But he also know that this is not normal through as well.”[JOSE]</p> <p>“Now, the person he works with, he’s also very much a spiritual person umm and he’s</p>
--	--	--	---

			<p>extremely in touch with nature and getting energy from nature. So the relationship between the two of them are dynamic, because they just clicked. Umm they get the energy level. Absolutely, so I thought that's great and it's not something I can actually offer my clients but clearly they enjoy it." [KRIS]</p> <p>"there is one lady who's very much encourage religious, like before they start their day everyone gets together they stand in a circle, somebody says a prayer, it can be anybody any kind of prayer... And for her, it is a positive motivation to get everybody ready for the day, a very peaceful frame of mind." [KRIS]</p>
			<p>Category 2: Information</p> <ul style="list-style-type: none"> Literature "I have become a lot more conscious of it when I have studied my Masters so I don't know if it's an issue of being expose to literature and to yar like the latest discussions of occupational therapy and yar that would influence your discussion into your planning and your vision around that." [KRIS] "it's probably also about my experiences in psychiatry and Western training that has contributed to my way of seeing things." [IMANI] Internet "I haven't use textbooks for those two cases. I used google." [JOSE] Organisation "... for the Muslim client it would be the MJC (Muslim Judicial Council), to give them the legal advice to help with divorce procedures." [IMANI]
<u>BYP 3-3</u>	Rewarding and challenging experience	Experience [3]	<p>Category 1: Rewards</p> <ul style="list-style-type: none"> Diversity acknowledged "what was nice was that, ..it also highlighted the different background <u>we</u> came from and despite that one could get along ..." [IMANI] Helping client

			<p>“...you help them to understand what it could be that the client meant or where the client would be coming from.” [IMANI]</p> <p>“I would have hoped that them being here for six weeks in general give them a sense of hope, that’s for me spiritual.” [SIYA]</p> <ul style="list-style-type: none"> • Witness clients improvement “it was quite emotional because it’s nice to see progress ... you would see a different feel of the client, it’s more realistic topics that comes up.” [SAI] • Mutually beneficial “The fact that [psychologist] was there, we spoke about it; sometime I was emotional I had to vent and same with her. So we became resource for each other.” [SAI]
			<p>Category 2: Challenges</p> <ul style="list-style-type: none"> • Expected to be a cultural expert “I think sometimes to be called on as an expert is problematic for me.” [IMANI] • Different professions working together “it’s kind of unpleasant because ... I am not the expert. ... So, when people come and ask me about [my religion]* I wished I had the answers but I actually don’t.” [JOSE] • Different professions working together “I think maybe there was ways but there was no space ...for it that we as a staff didn’t look at it [other ways of spirituality].”[SAI] • Emotionally difficult “I think it was difficult for different two professions. Because for me, you get the feeling the sense that now the group is tired and we need to stop now and the psychologist [wants to keep going] because there is more and more stuff coming out...”[SAI] • Emotionally difficult “As an OT for me it was difficult, ...a lot of things are coming out in OT and I don’t know

			<p>how to...facilitate. Like I had this boy once that said that I was gang raped and he never mentioned it anywhere else and I didn't know what to do with this information." [SAI]</p> <p>"you can't [just left it] because just the fact that he mentioned it, it's like I need help. ...it took him quite long to build that trust." [SAI]</p> <p>"...at times I was emotional because I also needed to vent because their stories became very [traumatic]." [SAI]</p> <p>"It was difficult to be professional and not to bring your personal things through the group." [SAI]</p> <ul style="list-style-type: none"> • Not always have an answer "I don't think we have arrived at a workable answer ... if workable you mean by is this psychosis is this health seeking or is this his way of expressing himself spiritually." [IMANI]
Commentary (other important points to make about the Quintain, possibly regarding a finding from a single case)			
			<p>"one thing that strikes me umm remarkably is that the profession of occupational therapy we have never, not once in the 13 years I have worked here in the department that we discussed spirituality as a dimension of occupation. [here?] yar, it's never been on our agenda. So umm that's significant. [KRIS] (an observation about OT by Kris)</p>

Appendix 10: Researcher Journal

[names of workplaces and colleagues are changed for confidentiality and the change is indicated by a * next to it]

Research Journal 2009-2010

FORMULATION AND INTERVIEWING PHASE WITH RESEARCHER'S FIELD OBSERVATIONS AS A CLINICIAN AS WELL

2009- 11-26: Occupational Therapy is a very spirited profession

Today I heard an occupational therapist saying that OTs are incredibly spiritual people - they hold on to something bigger because we can hardly identify completely with the purely 'simply magical powerful medicine' or 'science' or 'physiotherapy'.

I found this an interesting statement about OTs - we are about meaning, we want to help our clients do things that means to them. This make our pathways to health and wellbeing so different to other conventional health professionals - instead of 'intervening' to make them better, we believe in by doing and being in the basic everyday live activities and roles contributes to health. In fact, I think OTs find what is meaningful to themselves through helping others finding theirs in the everyday stuff.

What boggled my mind is this: if we are such a spiritual natured profession, why do we run from spirituality? Why is it that there are hardly anybody that is comfortable to just be in a therapeutic relationship with their client & feel their spirituality with them? Why are we afraid in challenging others (OTs, other HPs and clients) about the health giving and health damaging spiritual typed occupations? You understand the link between meaning and spirituality as well as that with health, to be holistic in your work with the clients you have gotten; you got to deal with it!!

2009-12-23: Spiritual experience at work (at least I see it that way)

I had often wondered upon OTs seemingly denial of their involvements in spirituality at work, even through what I had observed today at work was not about the patients as such; spirituality as a topic is still very much a part of our lives as professions and as people.

During the usual breakfast scene in the morning, a friendly group of OTs sit together and have general conversation about life and everything. Speaking about attending a wedding, to how

different cultures are, to how some people may be compliant about living next to a religious worship place that are not of their own one making too much noise with their means of worshipping (e.g. praying or bell ringing). Came out of that was a beautiful example of what spirituality can do for people..... One of the OTs was describing a TV show that she had seen describing how prisoners in a military jail of another country were denied of their human rights to starve strike as they will force feed the prisoners. The prisoners tell of how their singing of prayers in their isolated cells together collectively was what kept them going and was their means of protest. The OTs listening were all from the same religion of these prisoners and the story teller drew silent, almost in acknowledgement of the power and almost as if that story also touched them.

As the observing person who is the only person not in the same religion/spiritual orientation, I felt the power of those prisoners prayers, the triumph of human spirit and ability to find meaning and create meaning in the most inhumane and unjust situation. I cried a silent tear in solidarity with them just like those colleagues who grew silent in acknowledgement of the same power.

What an amazing awakening at work!!! Spirituality is all around us... it is above us, within us and amongst us.

2010 Jan 11: first presentation for recruiting participants at APH Hospital 1*

I was very pleasantly surprised by the way how the inside of APH hospital 1* look – it really had a relaxed, open place and olden feel to it. They had all sort of interesting buildings, like harmony hall which looked like a cone shaped windmill, recreational hall, open soccer field x 2, etc. Not the expected run down assumption I had when I base my expectation on the area it was located in.

With little bit of difficulty, I arrived on time for the presentation at 12h30 in the occupational therapy department. The APH hospital 1* department has 3 permanent OTs, 1 community services, 2 OTAs and a Physio (community service). This is somewhat smaller than I had expected and in light of the fact they had about 8 wards at least. This reminds me that I should probably talk to each head of departments for background information on their department for contextual information sometime in the future.

My presentation was simple and quick as its primary focus was to interest people and to inform them what it would involve and how they are protected. I decided to not include all the academic details as for one I hate to seem to know more than others and two I don't want to bore them with it. Everyone was quietly listening to my presentation and nobody had any questions except the head of the department which asked me 'where to from now'. So, the presentation was either boring or it

was so good that nobody had questions. As paranoid as it may be, deep down I am concerned that nobody understand my topic. I have yet to come across one OT outside of my supervisor, another lecturer who help the development of the study focus and myself understand it well enough first time round. This does bother me, is it that this is not important to OTs (this was not the case when I did the initial checking presentation at APH hospital 2* and certainly not in my own clinical practice where I believe I am touching it and doing it every single day of my work as an OT in mental health). What is more possible, perhaps is that it is not clear enough to them?

A few points for attention after the presentation

1) more selling – add why spirituality in mental health

? more personal – tell my own story about my first encounter with it??

I am meant to see who want to take part in APH hospital 1* by Friday and I am keen to do the interview next week already – Gosh, I just hope this is not going to flop ><

2010-01-15: Receiving 1st completed informed consent forms

Received one completed form from APH hospital 1* for my study – I am interested and frustrated about the fact that therapists felt they cannot locate clients in their heads when it comes to spirituality. They put it down to the fact that it is because APH hospital 1* is a place for intellectual disabilities – they don't have mental cognitive concept of religions or spirituality even though they may sing to a church song. Although there was one case where one patient came from APH HOSPITAL 2* that was non-English speaking, it took a long time for therapists to understand this patient's gestures as a spiritual expression.

This takes me back to my own HOD's comment when I started the preparation of the study, she felt that I would most likely find some people in admissions not so much forensics or anywhere else... Why is this so? I know that in for example the Muslim religion, if one have a chronic illness or not clear in their minds; they are not to engage with fasting which is a HUGE spiritual occupation in that faith. Are we saying that people with psychiatric illnesses are unable to appreciate spirituality? So, spirituality has something to do with thinking? To do with one's logical abilities to think and understand? If we are saying this, what about children and babies – do they then also have no concept of spirituality then? Just taking this in the lens of Christianity – some Christian branches (think it is the roman Catholics) say children or whoever else that is not confirmed are not allowed to receive communion because they don't know while other branches of Christian allow this. This is an interesting conflict that goes between the lines!! IS there power issue here – about who decides who knows and who do not? Is it really a fact that certain people knows and others don't?

I find this rather odd and hard to understand when I think I see spirituality so often in previous and

current clinical settings. And how is sing a church song not a spiritual natured occupation? If it does not mean or have purpose on a 'connected to higher being level', it means and have purpose on a connecting with self and others (may it be rather limited ways). Why is that not seen as spiritual? I find it hard to understand why do I see 'it' the way I do while others see 'it' the way they do?

2010-1-18: Running through interview with an informant

I ran through my interview protocol with an OT colleague at work today. It was a really interesting and anxious experience.

She said to me spirituality to her is something private and not out there on your face all the time, so when someone who is overtly religious (in patient context) that person would be really likely to be ill. I decided not to record her because she was not a participant and I didn't want her to be uncomfortable. We then attempted to go through the questions together and find big problems with the 1st one. Her comments included that:

- 1) it was too long and
- 2) some terms were confusing e.g. health seeking (what did I mean by that?)
- 3) She felt that it would be really important to allow people to define spirituality to begin with (for context and for icebreaking sake)
- 4) need to be clear that patient can be psychotic or well (* I found it interesting as she asked this as in spirituality may or should only exist when people are well?)

She then pointed out there are cases where it is obvious. E.g. "Arch angel" in her ward at the moment who seems really connected with a higher being but she is completely disconnected with others and herself around her. (? balance between connections)

This arch angel apparently does nothing else but lay in a 'cat stretch' position and flap her wings on the floor.

Seeing that it wasn't an interview I took the liberty to share my view and examples on spirituality as a political struggle, spirituality and substance in Rasta's with her. From there, she suddenly see my point and said "now when you put it that way, there is a lot of cases in my mind". She went onto sharing a case of a vegetarian who become very fixated on fruit only when she is ill ? this was interesting as it is rather ironic that eating fruits, going green or organic or raw and whole food are glorified in the media as the right and best thing to do for health. In her context, it is her mental illness costing her physical health as her hair start to fall and nails start to break from severe lack of particular nutrients.

Because I know that she runs cooking group, I asked her so did she ever come to your cooking group

– she did but at the time the group was making a fruit salad that day and it made her really happy however patient got discharged soon so didn't go to more cooking groups.

We both thought it would be interesting if she had come and discovered cooking group involved more than fruits.

Although I felt that both of us were uncomfortable doing this fake interview, I think this is really helpful to get real feedback from OTs about how I am asking my questions.

I have decided to downplay the big words as I don't want to have participation feeling nervous and therefore myself anxious too.

Another interesting point, she agreed with my HOD that OT is a rather religious profession – there is quite a lot of religious OT out there in her view, so she think I am going to get religion bit of spirituality from lots of people and that I may need to cue people into also exploring the other aspect of spirituality.

She also said that OTs may find it offending to think beyond spirituality as religion. I found this point truly fascinating as there I was furious with OTs for not looking beyond religion in spirituality after post APH hospital 1* recruit. She is giving me a different perspective that may offer me some explanation on what I am mad about.

She also said religion as spirituality is dominant and it will be what comes to people's mind at first. I suddenly felt that my research would be an eye opener for OTs rather than collecting much on it ?

Another issue I suspected will come is that when I wanted more details about the cases 'fruitian', my informant couldn't remember details as it was awhile back. ? Now this is going to be problematic when examining sp and clinical reasoning – so I think I need to ask people to look as recently as possible.

2010-01-18 (entry 2 – just my thoughts)

I suddenly had a wild thought – the combination of spirituality and Ubuntu. I had seen spirituality as the way people connect – when I help another person who happens to be my patient with their problems we connect and they light my spirituality. If we say it has to do with inclusion and connection – it sounds like Ubuntu does it not?

Why connect if you don't want to include someone? (yes, it is true that they maybe included in a way they are at the lesser end of the power dynamics).

In order to experience the connection you have with others, you got to feel compassion for them – the solidarity; the I want to stand next to you my brother. That compassion, that 'stand by me' is our OT's fundamental dance of holism and client centeredness. I feel that because of the above, to be a good OT you need to look into spirituality but to be an African OT – you have to and you must not only look at the person's but the persons' connected to the person you are dealing with.

I really think we ought to help our future OTs understands its importance and to give them the confidence to fight the biomedical world out there because we need to see the humans between the eyes of the body in front of us in therapy or else we are not different to our non-OT colleagues.

2010-01-19 First interview with P1

I arrived on time and found P1 waiting for me for the interview. After some small chat we started the interview which went as far as 49 minutes. I must say it didn't go as greatly as I wanted and hoped it to go (maybe I am just a little too hopeful). What is worth recording in this journal entry is the afterwards conversation that was off record.

The interview ended after I asked the participant what information or knowledge or models she might have used in her process of deciding. Off the record, she laughed and asked 'what models are there?' We spoke briefly about literatures and what I had found to be out there. She went on to say, the most important is that this occupation of spiritual natured need to mean something to the engager for it to be considered spirituality. She then also highlighted the complexity of clinical reasoning in the spirituality context – 'when you are depressed, doing what you did before that made you happy is not always going to make you happy again'. It was getting interesting, while P1 is saying 'how do you decide'; she's also highlighting the importance of OTs' clinical reasoning in getting the right fit. To add, we also entertained the idea that not long what is spiritual now is not necessary spiritual tomorrow. This is how we came to the 'conclusion' that an occupation of a spiritual nature is only spiritual if they are meaningful. P1 gave a personal example that 'sometimes I don't find it meaningful or spiritual at all going to religious meetings but I find doing something like watching a butterfly spiritual'.

Then out of curiosity, I asked her why is it that it felt like spirituality does not apply to intellectual disability (and that's why the response to take part in the study from this hospital was not great). She expressed that this is because the client base there are mostly functioning under 4 years of age in cognitive abilities so because there is a lack of conscious understanding or knowing of spirituality (I almost hear her message as 'how can it be spirituality when they do not know what it means'). I

think for this point, it will be interesting to hear what my supervisor thinks as she works on children and spirituality.

We went on to more personal discussion as I shared with her how I started becoming interested in this topic – about how traditional healers' becoming process is so closely lined with psychosis. She shared that one of her relatives who were studying to be a Western medical doctor felt that he was also called to be a traditional healer – yet he was coloured and not from a culture or family where traditional healer was in its history but he did live close to a Black community where he consulted another traditional healer about his calling. It is very interesting that Imani then went onto highlighting the problematic-ness of using the criteria of 'must be part of that person's culture or religion and must be consistence and appropriate as well as in line of that person's history and previous experiences' as in this case of her relative, it is the opposite for all these criteria for making it a 'healthy' or health seeking spirituality yet he is seemingly 'normal'.

*** *** *** *** *** ***

I am a little worried that she only spoken of team context in the interview where the OT did not make her own autonomic decisions about spirituality despite it probably means that this is good teamwork. She also only spoken about the past where she was a clinician in a different hospital while she is the manager of her current department giving her no more clinical exposures.

2010-01-25: Recruitment of participant at APH hospital 4*

This was a much more relaxed and subjectively successful attempt compare to the first try at APH hospital 1*. People seem interested and were asking relevant questions, I hope to get some of the ones that will diversify my research from APH hospital 4* seeing there is one guy there and 2 white middle age women. I am crossing my fingers those people will want to take part !!

I think it was definitely great to have added more on theories and little bit more clear about involvements and having said who approved my research also helps.

I will be getting the forms back on Friday – so I am crossing my fingers and wait to see ><

2010-01-26: Modesty in the eyes of Muslim OTs

As Imani had mentioned modesty in relation to the full keejap in the interview, I was particularly interested when the word 'modesty' was mentioned in relation to the way how Muslim women would dress. I went ahead to ask my Muslim colleagues to explain to me what it means to be 'modest'.

This conversation of modesty came up in relation to having noticed one of my colleagues' nails were stained with 'Hanna' (a dye that is used in Muslim traditions). The interesting thing is that according to this colleague of mine, Muslim are not suppose to put anything that water cannot run through it as they pray five times a day and each time they perform a special hand washing routine with it. Therefore, e.g. women would not be wearing nail polish unless one cannot pray anyways (i.e. when one have their periods). Therefore, it would be consider as not modest if you draw attention to yourself for anything other than to stand up for what is right (moral issues) and there are 'other' ways to beautify a Muslim woman. I felt this was contributive to my research and therefore decided to record it down.

2010-01-?: Presenting at APH hospital 4*

It was anxiety provoking to find APH hospital 4* as it is in an area that I don't usually go to. I arrived a few minutes late and was turning the wrong corners to get into the OT department. A patient sitting outside by himself saw that I was clearly lost and came to point out to me how to enter the OT department at APH hospital 4*.

After making a few more wrong turns, I found the OT department all sitting in a boardroom and having their staff meeting. There were quite a few people there today – I found it interesting how there were two older women that looked obviously senior to others that present (I wonder if they are chief OTs) – I was excited to see them as they were White which means that I may get them into my study for diversity; even through there would be little I can do if they didn't want to participate.

For this presentation, I added a few more literature orientating slides which I think really helped people to understand what I am presenting and wanting to research on. Questions were asked by one of the two Chief looking ladies about the amount of time needed for participation and there were a level of more interest from APH hospital 4* it seems. However, as I had presented at the beginning of their staff meeting; I didn't get to stay longer to see what level of interest is with the topic. No one asked clarifying questions, so I am hoping people understood.

We will wait and see what comes back from APH hospital 4*.

2010-02-05 presenting at APH hospital 2* and APH hospital 3*

It had been interesting with my own department (APH HOSPITAL 2*), it had taken a long time to organize this meeting as people are constantly busy, sick, on leave or unavailable to hear me.

There were a few interesting questions and comments from my department, which included the following:

- “what if this is not even something your team thinks about...” (this person want to come see me later on today/next week, so I am very keen to see what she’s got to say about my study).
- In response to this, another staff member commented that “well this may not be something in your head the whole time but for it may be... like for example patient XXX who’s illness is surrounded by his religious belief – so whoever had worked with him would really be an interesting case for the study” – (I worked with that person before, didn’t find it that interesting as his spirituality bit is really part of illnesses, but I guess I must find out who worked with him before as they maybe good for the study like this colleague said).
- Another person commented ‘you had come a long way since you started and presented to us initially before you even started working at APH HOSPITAL 2*’.

For APH hospital 3*

Once again, I got a little lost as most psy hospitals are rather big and OT was not really sign posted at APH hospital 3*. What was different through, the security didn’t know even how to direct me – so I am not sure why this is, I suspect that OTs are all over and they do not have their own department as such, rather they are one OT in one ward or one system.

When I arrived, they just had their very long staff meeting (about 1.5 or 2 hours long). I saw an old high school person there, was so interesting and touching that she remembered me (while I didn’t really remember her) and that we both from the same school ended up in OT and in psy OT as well.

The comments and questions after the presentations:

- 1) Someone was still confused about what I wanted – people still seems to not be able to get over the idea that I am only interested in the ‘how’ you decided and not ‘what’ you decided. – It had to be clarified again.
- 2) I was really avoiding this but one of them asked me to give them some examples – so in order to avoid too much telling I told them why I started the study (my fountain house case where the guy was writing and writing on the board about his Christian belief that staff ignored as they did not know how to engage with him about it – and that even through I didn’t know if he was ill or not; through the engagement of having someone being

interested in one's spirituality, this client brighten up which makes me think what if we can tell better when we should and when we shouldn't be doing it....) But I somewhat sense they wanted more, so I used the Rasta and dagga example with them – saying that OTs are health professional, we are employed to look after people's health, so in this case; one want to respect that Rasta's spirituality yet we know that dagga is going to make him/her sick – so what do one do as the OT there in that case? Yes we are enablers of occupational engagement and I know the OTs around the room there was agreeing with me on this one, however I turned it slightly again to say 'but we should also be there to warn if a particular occupational engagement will be promoting of ill health'. I can see the lighting up of their faces like they are hearing something new.

I hope I didn't put anyone off, I just couldn't resist sharing with them what my own view and opinions are about it. I believe that OTs are not just 'nice' people that will help you do whatever you want to do because it is meaningful to you, I believe that OTs also have a more protected and firm (the not so 'nice' friendly side of us) that will command respect from our fellow MDT members.

I also saw in the audience that there were a few smiles as I presented – I am hoping this means that there is interesting stories to be told. I was interested in the staffs that are there as well, people don't seem as big of an age gap as in the other 3 AHPs – I wonder what's special about them that they got more balance? And I also saw a male OT there, but I think he's only be working not for long – so unfortunately may fall outside of my study ☹

2010-02-12: Interviewing of P2

I arrived tired and on time for the interview with P2 at the hospital on the day. The patients had all gone 'resting' in the afternoon so the ward was very quiet. I was introduced to the nurses as we walked past the nursing office of the ward which I found interesting and makes me wonder about the power dynamics in the team (i.e. is she introducing me out of politeness to the nurses, are they nosy and have to know who I am or is there really good teamwork that P2 wanted them to know who I am?).

We spent a little time talking about the hospital where she works at first as I do not know the setting very well – which is a 'mistake' I tried to correct since interviewing P1 realizing I need to actually write a rather thick description of the context with the results (of which I am still unsure what it is as yet). She spoke of changing from male admission to female – the difference being male is very difficult as it is tough to cope with the rapid turnover with patient coming through while female seem slower and easier to work with. It appears that working at male admission was not as pleasant to P2 than her current post at female. Being the male OT at APH hospital 2* myself, I felt confirmed with my own disappointment and continuous heighten level of anxiety and frustration as well as isolation about working in a really fast turning system. I felt slightly cheated for having being put in male by my seniors while also am in wonder about what they see in me in terms of having an ability to cope like this. P2's workplace is very different from APH hospital 2* in terms of OT department

arrangements. There seems to be no such thing as a 'OT dept', all OTs are attached to their wards, run their own voc rehab (which she says she has OT/nursing student looking after while they are around) while the program focuses on voc rehab in the morning for 4 mornings a week and 4 afternoon leisure group (i.e. art, craft, bead etc) while Friday is an admin day for her. This means that patient have to slot into the running program and there will be an attempt to make their intervention client centered but it will have to be negotiated with the rigid OT program that is occurring at ward level.

About the interview itself, it was shorter than P1's. I wonder if years of experience have to do with this as P1 had more to speak about. I certainly think that P1's complex view of spirituality meant that she had more to tell me than P2 who see spirituality as only being 'higher being'. I was very disappointed with her seemingly limited view of it as it only touches the surface of spirituality and that it is the dominant stuff – and I am not really that interested in dominant stuff as the clinical reasoning process is likely to almost always point to spirituality as illness in those cases which is in my view very boring. I continued to feel disappointment about how 'easy' the reasoning seemed to her, maybe it is because she has a limited view on spirituality and that in that limited context; spirituality in mental health is almost 100% illness in the acute phase where she is sitting. I would like to dare myself to ask her in follow up meetings/phonecall about the other connections as I was very disappointed – for some reason, I expected a Hindu person to be much more in tune with connection to nature and self. Perhaps I need to go read it up!

About P2: She's Hindu and even though she seems and expressed herself as open minded, she only looked at spirituality as the higher being. She mentioned other aspects of spirituality but she doesn't pick it up as spirituality. She just doesn't seem to see the other non-dominant aspects of spirituality as spirituality – in her own words she would say xyz but that's not spirituality through etc (I can imagine her saying that). I felt I was unable to ask her seeing she didn't have 'insight' into the other aspects. I feel a little regret about not doing so but I also felt that if it is her view I should respect her knowledge base and not to 'challenge' her as such on it.

Another interesting aspect of this interview was the chat we had outside as we getting into our cars to go our separate ways. I expressed my gratitude for her participation as I had been having difficulty in recruiting OTs into the study – on average there was only one person in each APH that was willing which leave me with no choice in terms of diversity issues. P2 had an interesting comment that perhaps the topic intimidates people – as if this is some higher grade academic exercise. I appreciated her input into my insight about the lack of willing OTs but however I feel slightly angry with the 'intimidated' – the reason why I was coming to them was I wanted to learn and I believe they knew... Perhaps they didn't? Or perhaps as P2 said, even through unrelated; as an OT working in mental health, when we go home at the end of the day we want 'me times' we want to be alone and not to interact as we are tired from interactions with patients all day which our

partners/families cannot understand. Now if the OT is so overwhelmed by our responsibilities at acute level – would it be justifiable that they forget spirituality while their system and ‘bosses’ want them to go more biomedical framework of which chucks spirituality out of the wards? This is an echoing message I had been getting – which saddens me as I believe OT really know so much about spirituality and how it can come in occupation forms that will be health giving and we are not allowed to do our best as other more powerful figures want us to turn away from our core business of sorting out occupational justice issues.

2010-02-18: Interviewing with Siya

As soon as I walked in, I was amazed at the difference of the neuroclinic and the rest of the wards in the hospital. There are long narrow corridors offices for each MDT member on the left hand side which is unusual in the female/male admission where the MDT work in more than one ward. Everybody is in casual clothes – no one is in their uniform, so it is hard to tell the staff and the patients apart ☺ In some ways, in fact; this is rather nice.

I began the interviewing process by asking about the background and context information about the neuroclinic – knowing that Imani worked here before as well so I felt it will be really good to get some more details about the context itself. I spent a little bit longer than I usually would on this part of the interview as P3 was clearly anxious about being interviewed regarding spirituality despite she was brave and made herself available to participate. This anxiety had been expressed by her when she came to see me before she signed up to the study. Siya was particularly nervous about the confidentiality aspect – of which I assured her about.

Perhaps due to her vagueness, we spent a great deal with time looking at very general description of spirituality and what is happening in the ward. She really didn't have much cases to talk to me about until the very end where she mentioned two cases where patients had went to seek advice for health from the traditional healers (Sangoma's) which ended very badly. The woman case in this two got raped while the man lost a huge amount of money and lost his job (as he was told to quit it). However P3 was unable to tell me any details of her reasoning so it was not particularly helpful for my study. I was rather disappointed, she continued to look anxious. Seeing the fact is I have two willing OTs from APH HOSPITAL 2*, I am considering also interviewing the other one and hope that there is more in that other case than Siya.

I think Siya's lack of depth in her interview is not only based on perhaps she really hasn't think about spirituality in her practice to work with it as such – in fact, I think this would be a really small part of it but I believe there is something even more...

- 1) Siya was having a really bad day – she was told that it's her 'poor management' of a particular case who became suicidal again in the last week of this patient's 6 week process. SIYA expressed in the interview that she feels dishearted and that it is unfair comment to make when the patient has rather deep dependent personality disorder as personality is not something easy to change.
- 2) The ward in which SIYA is currently working is also under a lot of discussion of change due to the pressure that there is in the system – There are so much pressure from the referring hospitals with regards to acute mental illness admissions, this had been observed to be demotivating for SIYA. In fact, SIYA had struggled to have an OT identity in this ward as the only OT interventions input she really has is the two lifeskills sessions that she does with the patients while she is also expected to do a bit of social work – looking for accommodations etc. She would like to get more involve with psychotherapy groups in her ward but time constraints and potential professional territory marking may hinder her entry into spaces that are meaningful to her.

This was not a particularly helpful interview – I felt that SIYA didn't actually meet the criterias of having at least two cases to talk to me about in the interview in which I can explore clinical reasoning process and hence it was impossible to explore what resources she used as such. I will check with my supervisor and see if it's okay I erase her from the participants to put the other OT from same APH as SIYA.

Interview with P4

It was very exciting, it really was wonderful, it was what I was looking for.

P4 took me around to see the ward first. The ward was very stunning looking, new and colourful. P4 took me to look at the dormitory and seclusion room – they were small but the dormitory was nice, it looks like privacy is respected in the PRU while I was surprised by the seclusion as I was expecting a bed to be in there while P4 explained that they only put people in there for 20 minutes 'time outs'. P4 had her own office there, cosy and small. The ward had an OT room which I think was decent. The OT room had a range of activities there, lots of basic task orientated occupational engagement like art and craft. They working on component things, like concentration and following instructions and it's interesting to hear that she takes on two wards (LAU and LPRU). There is an art project an OT that did with the patients and a few of inspirational quotes were painted on the wall as well. One thing interesting I saw in the ward, there was a Jewish evil eye and hand sign hung on top of the visiting room opposite the nursing station. This is interesting as this unit appears to be more open minded (or perhaps at least it is more present) about spirituality and religions as compared to other participants who told me mainly that it is an unspoken and hush hush topic that is still a little taboo.

The OT programs across two wards:

I am also very amazed how big the hospital where P4 works is – there is 108 wards in this place and that is probably why the OT department is so fragmented - OT is not in every single one of these

wards. There were OT in vocational rehab and lots in IDS, admissions had two wards and forensics (both male and female, there were more men still through), 1 neuroclinic and two adolescence unit.

PRU – OT time in the morning – groups and individuals, drumming in afternoon; very interesting is that physio do the yoga and sport groups – and OT do these at APH HOSPITAL 2*! P4 told me that the physio sessions are for general health and fitness not as I thought (which is maybe it's for psychomotor retardation and catatonia). Patients also have basic schooling sessions twice or three times a week while CAPREX (i.e. ward round) happens 3 times a week. We saw OT programs at her office – lower functioning are occupational engagement in tasks and activities which are OT led. For the higher functioning people which is more in LAU where you look at life skills and more discussions.

LAU and PRU is located within the WCRC separated from the general acute admission and forensics in the bigger side of the hospital. P4 told me that LAU and PRU was grouped together with IDS unit where there are also more physical components to it.

Interview itself

It was very interesting to talk to her – It is interesting that she also started at male admissions, people at male admissions do not stay very long (I wonder what is the condition of male admission that makes OTs unlikely to stay long, it seems rather usual that someone will start at males and then move over and across to other things in psy.) This is the case for P2 and P4's workplaces.

Interesting was definitely the group that she ran with the psychologist where lots of spirituality stuff came out. But her view for spirituality was really just higher being – even through I really cued her about the other aspects of spirituality and she just didn't get to them. I was irritated to the fact that despite spirituality as the four connection were presented in my recruitment presentation; the higher being is still so dominant that it almost appear the other don't exist. I was slightly disappointed that nobody seems to think or talk about spirituality as a higher being, I was really out there to prove that there was more and you need to look at the more and you are not looking at it. I guess this is my own biases and it needs to come out. Only P1 was able to begin to consider all the different ones. I didn't want to say it and direct the interview in such a way that it will be close questions. Instead, I rather her talk about more what she was on about and that is what I tried to do in the interview with P4.

It was amazing that she identified the need of spirituality from the patients and that she went and started a group with it. I really think it was really amazing – although she kept saying it is spirituality as a higher being higher being, actually what she was doing with the patients was spirituality as in getting in touch with myself through introspection.

It was very encouraging to see two disciplines together to do something about spirituality issues having planned an action after seeing a need. In this case, it is OT that who cannot see spirituality beyond the higher being; she also see herself unable to do the deeper and digging in to the psyche things with the patients (which I think is connecting with yourself – looking inward) and she actually call on the psychologist who she believe was more able to do this to come in and run the session together. This is really courageous of her that she knew her boundaries and she recognizes them and called on others when she needed to. The teenagers' issues were rather hard to deal with – e.g. Raymond with his sexual orientation issue, he found guidance and help from spirituality (in the form of having 30 mins quiet time to read the Bible) – I was amazing and think this is really quite something positive and encouraging from P4's story.

It feels nicer and friender. Nurses are running groups in the wards which does not happen in APH hospital 2*, so this is rather interesting in what there is. I felt that P4 really knew what she was talking about, it was really amazing and I really enjoyed the interview.

2010-02-23: At work: Problem with yoga

Interesting how boss got really upset about yoga. Her view is that we at our workplace want yoga as an activity not as therapy which is contradicting the philosophy of those who take it really seriously as in a way of life.

And I am not sure where I stand with this, which is why I thought it is worthwhile to write my own experience down as a clinician inside the field I am trying to research in. As much as I was suspicious of the facilitator that came to facilitate yoga as she didn't appear to have understanding of what we need and what we are wanting from yoga for the patients (i.e. perhaps my boss's view); I connected with her contemporary way of practicing for mental health issues. I ask the question within myself – can biomedical approach really not live with contemporary approaches? Is it really have to be so polarized?

2010-03-15: Interview with P5

It was not that much of an exciting interview as I had anticipated, perhaps because P5 had have done a masters in OT and hence I was expecting a lot more out of her than I was with the other participants that I didn't know as well.

What was interesting was that P5 see spirituality as positive and health giving and has a lot to do with meaning. So the ill health aspect/component/ side of spirituality is not seen as spirituality at all in her view because that would be part of the person's illness. She have had quite a few briefly described cases in the interview in which she just dealt with it, she didn't expressed a struggle and she just did it. Is this because she was very experienced (with over 15 years of working in psychiatry) or does this have to do with her masters in OT having given her a different way of thinking? Or does it have to do with the way she viewed spirituality in occupations? It almost appeared that there are criteria for her to decide:

- 1) not all cases there is spirituality, if there is; it must speak into the meaning creation for the person. Hence, spirituality is not the centre of all and every patients' occupational therapy intervention (esp when it is not particularly expressed as an area of concern) but because she sees spirituality as a source of meaning, and that she goes into meaning search with her patients in planning their programs; it is addressed in a sub-dominant way.
- 2) Religion/religiousity is often associated with delusion – it is tough for us as health professional to engage with spirituality for this reason when it is looking specifically on the 'connection with higher being'. If this is the case (in which she judges as ill health, she chose not to actively engage with that and monitor to ensure prevention of relapse or worsening of daily functions).

Interesting observations and what we spoke about off record:

- 1) P5 was worried about not having read up anything before the interview as preparation and asked me what I see as spirituality.
- 2) The interview happened at Ward 20 (max security), it is not as scary as I remembered it as a student. It was rather quiet and pleasant in fact – not as chaotic, dirty and full of inappropriate patients as I remembered – I guess perhaps I didn't go into the actual ward where the patients are.
- 3) P5 made the comment about spirituality has not been discussed by OTs at a professional level in psychiatry (she was particularly referring to her workplace). We were saying that OTs are spiritual people esp if we take our colleague in the same department but they only speak about spirituality in relation to themselves personally not as in how are we going to put it in with the OT program. This have left me wondering why do we not talk about it?
- 4) Forensics' philosophy about Rastafarian and their dagga use: P5 was saying that it should be the behaviours associated with the effect of having smoked dagga that is to be punished not the fact that dagga use is part of the Rasta faith. For example by not allowing dagga users to work at say voc rehab, we are not doing those patients justice / favour as they would be deprived of working occupational opportunities. This is an interesting and controversial point of philosophy as where should client centredness be placed
 - a. Is it at individual level like P5 is kind of saying?
 - b. Is it at populational – so for the sake of the other 49 in the area; you are not allowed no matter what?

DATA ANALYSIS PHASE

2010-6-2 Post first cross analysis

I had just completed first (and superficial) cross case analysis of the cases and I am confused into what exactly I am looking at.

I had organized my data according to my research objectives. It appears the working with spirituality as an issue by OT is dependent on a few things:

- Context – its demands on the occupational therapist.
 - What does the MDT believes about spirituality.
- Availability and for what purpose are resources within & outside the MDT used.
- OTs' own attitudes and their unique personal history as OT and as people.
- The clients' contributions.
 - o The working of all the above influence the experience of the occupational therapist in their history of working with spiritual natured occupations with their clients.
- There are some contextual issues that translate into subsequent positive or negative experience. However, there are some contextual issues that are influential but does not always translate directly.

I have a good idea what each participant is telling me but I am unsure of what is the bigger picture when I put all of their voices together. And above all this, how the Stake's method work after I have worked out all the cross analysis themes.

Comments on the participants:

- 3 out of 5 has a Masters degree, 2 in OT and 1 in public health.
- The same 3 out of 5 have more than 10 years of experiences in mental health while the other two with more than basic experiences (2-3 years).
- Choosing names for participants:
 - o P1: Imani (peace)
 - o P2: Jose (unisex – God will add – American/Hebrew)
 - o P3: Siya (love)
 - o P4: Sai (the saint)
 - o Jose P5: Kris (short sword Indonesia – with mystic power)

MEMBER CHECKING PHASE

2010-8-4: Member checking with Siya

Siya was happy with the findings and said that she was able to hear her voice in the findings. She was also surprised with what others had said about their experiences. The limiting OT role within the very strict therapeutic program was still an influence in her workplace. She also asked researcher about how the findings can be used clinically. Researcher spoke of a recent experience of spirituality coming up as a question by outpatient group (fear of being too spiritual as it is associated with being sick. Religious leaders viewed not accepting of illness – illness = impurity that can be prayed for and healed while clients also know that they need the medication. Siya did not report any cases that she may have experienced discernment about such occupations since the last interview. She attributed the limitation of the occupational therapist role as the reason why she hasn't had such experience as it is already hard enough to be an occupational therapist while she's supposed to work as a key worker (who has to do discharge summaries, accommodation issues etc as well). However, Siya spoke of potential changes happening in her workplaces may lead her into having more opportunities soon to look into mindfulness and group work which may have the potential to enable openness to look at spirituality if it becomes an issue for clients. She described the ward staff has inflexible 'they don't like anything beyond... when they have to make extra effort'.

2010-8-10: member checking with Kris

Had another member checking with Kris. Kris was happy with the findings and was able to hear her voice in the findings. When asked if she had any comments or was there any surprises from the data, she was surprised that nobody had said church was a resource as an organization as she found them sometimes helpful in terms of giving guidance to clients of hers when they needed it (in relations to MJC being mentioned by Imani as a resources for her Muslim clients when they were going through divorce). She expressed that there had been so little time since we met for the interview in her daily schedule, she hasn't thought more about spirituality and occupational therapy in psychiatry in these few months.

Kris advised me that I should consider publishing the journal article in an international journal but name it as a South African study. I was happy that she seemed to have valued my study.

2010-8-13: Third member checking today with Jose

Jose's ward had just had a woman's day celebration. As we entered her ward, I see rows of women sitting in front of 3 with Noleen on the tv. I suddenly also noticed the hyperorganisation in her workplace, unlike my own; Jose's workplace had electrically controlled gate at the security checkpoints and the ward didn't have security but instead they had thin computer monitors with

nursing staff monitoring who's at the gate of the ward through security camera. I cannot help but ask myself, why is there a difference seeing all the APHs are government services.

We got chatting about life in general for a bit before we moved onto the research findings. Like Kris and Siya, Jose was happy with the findings with little comments. She expressed interest in reading my study in detail. I once again reminded her that I will be emailing her my thesis when I am done and once I have a journal article I would want to do the same as that would probably be a easier read than the large document of the full thesis. She expressed that she was excited for me and looking forward to read it when it's completed.

2010-8-16: Member checking for Imani (previously P1)

Imani seemed to be busy as ever in her office at the admin building when I arrived for the member checking we have arranged to happen. I didn't know she had this office as I was expecting to see her at the OT department. As I was driving around the hospital, I see friendly patients at work with some gardening, helping out with some building work. It was very heartwarming to see for me actually; despite I have seen how staff can get impatient with ID patients.

The member checking went very smoothly like the other three that I have already had. Imani felt that she was represented and was comfortable with the quotes I used from her interview. When I asked her if there was anything surprising or stood out for her, she said two things. One, she was surprised that she was not alone in her feeling of uncomfortableness about being expected as a cultural expert. Two, that it was surprising true that we don't really deal with spiritual natured occupations too differently to the way we do with other occupations that would have not been labeled as spiritual natured. Like for example, yoga and relaxation can be seen as a kind of exercise but when you say it has a spiritual dimension to it, OTs start to panic in being anxious about so how are they going to deal with it? Imani asked me a valid question of what I was hoping to have coming out from 'now you got your findings'. It was a question I had been asking myself actually. I found myself answering in the following way, which I think perhaps may form part of my discussion once I have checked that this is clearly linked to my findings:

- I would like to increase awareness of OTs' role in working with occupations with spiritual nature because it is actually not all that differently dealt with by us. Besides, in line with the new literature I was reading – I really think we as OTs have a role to play in promoting holistic care and consideration of clients in mental health services that want to deal with their illness in culturally appropriate ways. Just like one of my client said to me last week how he's looking forward to 'cleansing ritual' at home when he's discharged from hospital.
- I would like to formalize and consolidate my findings into some form of a check list or a list of critical check points that is available to occupational therapists as a reference guide to help them think through their cases. And in addition, some of what and how we observe them should be taught to the client to empower them in 'checking themselves'.

I am very exciting about my study at this stage where I am beginning to pull the links together. I thought of a few things that maybe what I want to say in discussion:

- Occupation comes first, spiritual or not – OTs we still need to stick to client centeredness and understanding and facilitate the meaning about an occupation.
- Human as interdependent occupational beings – the previous reasoning really considered the client and what they are doing but in our case when we looking at clinical reasoning for occupations of spiritual natured, despite we follow similar route in our reasoning – we put the environmental/political part of our reasoning as priorities much more than 'just any other occupations'. **(or this point should be called something like political or communal/environmental navigation reasoning – it's about how it would work or not in relation to others)**
- Implication of occupational therapy
 - In mental health services
 - This is an area that we can potentially be the holistic, humanistic and non-judgmental therapist we suppose to be. By ignoring or avoiding the issue, it is an ethical issue to the rights of the person to express their spirituality. Beyond the issue of rights, it is also about attempting to be more equal with our clients. To allow them to show us their spirituality and allow ours to be influenced by theirs. **(I know some people are going to think I am romantic but think about it – the reason we don't allow them in; is it really 'it's not about me' or is it my defense mechanism?)**
 - In South Africa
 - What about African spirituality? The role of OT in enabling or cautioning about rituals in cultural ceremonies which makes the development of an African.
 - The use of occupations of spiritual nature to enable community reintegration, destigmatisation of mental illness – USE Ubuntu!!
 - Global
 - Call for therapist to reflect – the true meaning of client centredness and holistic approach to clients' health and wellbeing (hence OTs, come on; don't run away from this).

2010-08-29: member checking with Sai

I went to do my last member checking with Sai after struggling to get hold of her and have the time to get hold of her. This was my last member checking, so I was very happy that I was finally doing it. It feels like it is coming to an end, it's like having reached a different stage.

The place Sai works is very big, the sign posting to the hospital itself was great. You just follow the signs but once you got in, one can drive round and round before you end up in the right place where you meant to be. Seeing Sai was going to be rushing into a meeting in 45 minutes time when we started, we met at the cafeteria of her hospital. It was nice, friendly and quiet. Before I started, we had some short small chat and there was news that I had discovered. Sai had moved from her original ward to the one she was doing the spiritual group in. Out of curiosity and wanting to know if she had restarted that interesting group with the psychologist, I asked her about it. Her response was "no that group is long gone. We have had another psychologist just started again as well. And

the focuses had changed like I told you, from therapeutic unit to more acute. So now, I focus more on the pre-discharge ward while OTAs does the task orientated groups in the previous ward I was in". This was kind of sad as I believe that there was so much value in the group she had attempted as discussed in the interview. However, perhaps it points hardly to the fact that context matters - as in place and time as it appears that Sai could not go back to where that group was possible anymore.

Like other participants, Sai was happy with the results, able to see her own voices amongst the findings and was expressing that she was glad to see that she was not alone, a lot of OTs were dealing with and working with similar issues. I took the opportunities to show her what I had recently developed (others didn't see it because I didn't finish the PowerPoint yet by the time I member checked with them). She said that the PowerPoint had a lot of sense and was clear. It was a reasonably easy member checking and was done detailedly even though we needed to do things fast.

Now that I have searched through 4 databases for theories and literatures to write my discussion with. I must now read. During the search, I found 3 very recent (as in this year or last) PhDs and books chapters. it is so frustrating that they are not available yet (the book is coming out hot of the press only mid Sept 2010) and the PhDs are from overseas which will cost me and time to get to me. There is great irony in this as one as a researcher, you would like the most up-to-date literature in your study, however they are inaccessible to you. What was exciting for me, is seeing that I am writing topics that are so close to what's currently of concern and being discussed and published about. It gives me hope that South African researchers are at the tip of what's current despite Cape Town seem to be almost the Southern tip of the world!!